

103<sup>D</sup> CONGRESS  
2<sup>D</sup> SESSION

# S. 2374

To improve the United States private health care delivery system and Federal health care programs, to control health care costs, to guarantee access to health insurance coverage for all Americans, and for other purposes.

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## IN THE SENATE OF THE UNITED STATES

AUGUST 9 (legislative day, AUGUST 8), 1994

Mr. DOLE (for himself and Mr. PACKWOOD) introduced the following bill;  
which was read the first time

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## A BILL

To improve the United States private health care delivery system and Federal health care programs, to control health care costs, to guarantee access to health insurance coverage for all Americans, and for other purposes.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

1   **TITLE I—AFFORDABLE HEALTH**  
 2       **INSURANCE COVERAGE**  
 3       **Subtitle A—Tax Incentives**

4   **SEC. 100. AMENDMENT OF 1986 CODE.**

5       Except as otherwise expressly provided, whenever in  
 6 this subtitle an amendment or repeal is expressed in terms  
 7 of an amendment to, or repeal of, a section or other provi-  
 8 sion, the reference shall be considered to be made to a  
 9 section or other provision of the Internal Revenue Code  
 10 of 1986.

11       **PART I—EQUITABLE TAX TREATMENT OF**  
 12       **INDIVIDUALS PROVIDING OWN HEALTH CARE**

13   **SEC. 101. DEDUCTION FOR INDIVIDUALS AND SELF-EM-**  
 14               **PLOYED INDIVIDUALS PROVIDING OWN**  
 15               **HEALTH INSURANCE.**

16       (a) GENERAL RULE.—Section 213 (relating to medi-  
 17 cal, dental, etc. expenses) is amended by adding at the  
 18 end the following new subsection:

19       “(f) HEALTH INSURANCE COSTS OF INDIVIDUALS.—

20               “(1) IN GENERAL.—The adjusted gross income  
 21 limitation under subsection (a) shall not apply to  
 22 amounts paid by an individual during the taxable  
 23 year for qualified health insurance costs (and such  
 24 amounts shall not be taken into account in deter-

1 mining whether such limitation applies to other  
2 amounts).

3 “(2) QUALIFIED HEALTH INSURANCE COSTS.—  
4 For purposes of this subsection—

5 “(A) IN GENERAL.—The term ‘qualified  
6 health insurance costs’ means amounts paid for  
7 insurance described in subsection (d)(1)(D)(i)  
8 for the taxpayer, the taxpayer’s spouse, or any  
9 dependent (as defined in section 152).

10 “(B) LIMITATIONS.—For purposes of sub-  
11 paragraph (A)—

12 “(i) NO DEDUCTION FOR EMPLOYER-  
13 SUBSIDIZED HEALTH COSTS.—Qualified  
14 health insurance costs shall not include  
15 any amount paid for insurance coverage of  
16 an individual for any month if the individ-  
17 ual is eligible to participate for such month  
18 in an employer-subsidized health plan  
19 maintained by any employer of the tax-  
20 payer, the taxpayer’s spouse, or any de-  
21 pendent.

22 “(ii) PHASE-IN.—In the case of tax-  
23 able years beginning after 1993 and before  
24 2000, only the following percentages of the

1 qualified health insurance costs shall be  
 2 taken into account:

<b>“If the taxable year begins in:</b>	<b>The applicable percentage is:</b>
1994 or 1995 .....	25 percent
1996 or 1997 .....	50 percent
1998 or 1999 .....	75 percent.

3 “(3) DEDUCTION NOT ALLOWED FOR SELF-EM-  
 4 PLOYMENT TAX PURPOSES.—The deduction allow-  
 5 able by reason of this subsection shall not be taken  
 6 into account in determining an individual’s net earn-  
 7 ings from self-employment (within the meaning of  
 8 section 1402(a)) for purposes of chapter 2.”

9 (b) DEDUCTION ALLOWED AGAINST GROSS IN-  
 10 COME.—Section 62(a) (defining adjusted gross income) is  
 11 amended by inserting after paragraph (15) the following  
 12 new paragraph:

13 “(16) DEDUCTION FOR HEALTH INSURANCE  
 14 PREMIUMS.—The deduction allowed under section  
 15 213(a) for amounts described in section 213(f).”

16 (c) EFFECTIVE DATE.—The amendments made by  
 17 this section shall apply to taxable years beginning after  
 18 December 31, 1993.

## 19 **PART II—MEDICAL SAVINGS ACCOUNTS**

### 20 **SEC. 111. DEDUCTION FOR CONTRIBUTIONS TO MEDICAL** 21 **SAVINGS ACCOUNTS.**

22 (a) IN GENERAL.—Part VII of subchapter B of chap-  
 23 ter 1 (relating to additional itemized deductions for indi-

viduals) is amended by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

**“SEC. 220. CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.**

“(a) DEDUCTION ALLOWED.—In the case of an eligible individual, there shall be allowed as a deduction the amounts paid in cash during the taxable year by such individual to a medical savings account for the benefit of such individual or for the benefit of any spouse or dependent of such individual who is an eligible individual.

“(b) LIMITATIONS.—

“(1) ONLY 1 ACCOUNT PER FAMILY.—Except as provided in regulations prescribed by the Secretary, no deduction shall be allowed under subsection (a) for amounts paid to any medical savings account for the benefit of an individual, such individual’s spouse, or any dependent of such individual if such individual, spouse, or dependent is a beneficiary of any other medical savings account.

“(2) DOLLAR LIMITATION.—

“(A) IN GENERAL.—The amount allowable as a deduction under subsection (a) with respect to any individual for the taxable year shall not exceed the lesser of—

1 “(i) \$2,000 (\$4,000 in the case of a  
 2 medical savings account established on be-  
 3 half of more than 1 individual), or

4 “(ii) the high deductible health plan  
 5 differential.

6 In the case of a married individual filing a sep-  
 7 arate return, clause (i) shall be applied by sub-  
 8 stituting ‘\$1,000’ for ‘\$2,000’ and ‘\$2,000’ for  
 9 ‘\$4,000’.

10 “(B) HIGH DEDUCTIBLE HEALTH PLAN  
 11 DIFFERENTIAL.—For purposes of subparagraph  
 12 (A)(ii), the high deductible health plan differen-  
 13 tial with respect to any individual is the amount  
 14 by which the cost of the high deductible health  
 15 plan in which the individual is enrolled is less  
 16 than the cost of the health plan providing the  
 17 FedMed benefit package (within the meaning of  
 18 section 21115(b) of the Social Security Act).

19 “(3) PHASE-IN OF DEDUCTION.—In the case of  
 20 taxable years beginning after December 31, 1994,  
 21 and before January 1, 2000, only the following per-  
 22 centages of the deduction allowable under this sec-  
 23 tion (without regard to this paragraph) shall be al-  
 24 lowed:

**“If the taxable year  
 begins in:**

1995 ..... 25 percent

**The applicable  
 percentage is:**

**“If the taxable year  
begins in:****The applicable  
percentage is:**

1996 or 1997 .....	50 percent
1998 or 1999 .....	75 percent.

1       “(c) DEFINITIONS AND SPECIAL RULES.—For pur-  
2 poses of this section—

3               “(1) ELIGIBLE INDIVIDUAL.—The term ‘eligible  
4 individual’ means any individual—

5                       “(A) who is covered under a high deduct-  
6 ible health plan during any portion of the cal-  
7 endar year with or within which the taxable  
8 year begins, and

9                       “(B) who is not eligible during such cal-  
10 endar year—

11                               “(i) to participate in an employer-sub-  
12 sidized health plan maintained by an em-  
13 ployer of the individual, the individual’s  
14 spouse, or any dependent of either, or

15                               “(ii) to receive any employer contribu-  
16 tion to a medical savings account.

17       For purposes of subparagraph (B), a self-employed  
18 individual (within the meaning of section 401(c))  
19 shall not be treated as his own employer.

20               “(2) HIGH DEDUCTIBLE HEALTH PLAN.—The  
21 term ‘high deductible health plan’ means a health  
22 plan which has—

1           “(A) a deductible for each individual cov-  
 2           ered by the plan which is not less than \$1,000,  
 3           and

4           “(B) a family deductible which is not less  
 5           than \$2,000.

6           “(3) MEDICAL SAVINGS ACCOUNT.—The term  
 7           ‘medical savings account’ has the meaning given  
 8           such term by section 7705.

9           “(4) TIME WHEN CONTRIBUTIONS DEEMED  
 10          MADE.—A contribution shall be deemed to be made  
 11          on the last day of the preceding taxable year if the  
 12          contribution is made on account of such taxable year  
 13          and is made not later than the time prescribed by  
 14          law for filing the return for such taxable year (not  
 15          including extensions thereof).”

16          (b) DEDUCTION ALLOWED AGAINST GROSS IN-  
 17          COME.—Subsection (a) of section 62 (defining adjusted  
 18          gross income), as amended by section 101, is amended by  
 19          inserting after paragraph (16) the following new para-  
 20          graph:

21               “(17) MEDICAL SAVINGS ACCOUNTS.—The de-  
 22               duction allowed by section 220.”

23          (c) CLERICAL AMENDMENT.—The table of sections  
 24          for part VII of subchapter B of chapter 1 is amended by  
 25          striking the last item and inserting the following new item:

                  “Sec. 220. Contributions to medical savings accounts.”



1 (d) EFFECTIVE DATE.—The amendments made by  
 2 this section shall apply to taxable years beginning after  
 3 December 31, 1994.

4 **SEC. 112. EXCLUSION FROM INCOME OF EMPLOYER CON-**  
 5 **TRIBUTIONS TO MEDICAL SAVINGS AC-**  
 6 **COUNTS.**

7 (a) IN GENERAL.—Section 106 (relating to contribu-  
 8 tions by employers to accident and health plans) is amend-  
 9 ed by adding at the end the following new subsection:

10 “(b) CONTRIBUTIONS TO MEDICAL SAVINGS AC-  
 11 COUNTS.—

12 “(1) TREATMENT OF CONTRIBUTIONS.—

13 “(A) IN GENERAL.—Gross income of an  
 14 employee who is covered by a high deductible  
 15 health plan of an employer shall not include any  
 16 employer contribution to a medical savings ac-  
 17 count on behalf of the employee or the employ-  
 18 ee’s spouse or dependents.

19 “(B) NO CONSTRUCTIVE RECEIPT.—No  
 20 amount shall be included in the gross income of  
 21 any employee solely because the employee may  
 22 choose between the contributions described in  
 23 subparagraph (A) and employer contributions  
 24 to a health plan of the employer.

1           “(2) DOLLAR LIMITATION.—The amount which  
2           may be excluded under paragraph (1) for any tax-  
3           able year shall not exceed the lesser of—

4                   “(A) \$2,000 (\$4,000 in the case of a medi-  
5                   cal savings account established on behalf of  
6                   more than one individual), or

7                   “(B) the high deductible health plan dif-  
8                   ferential.

9           “(3) HIGH DEDUCTIBLE HEALTH PLAN DIF-  
10          FERENTIAL.—For purposes of paragraph (2)(B), the  
11          high deductible health plan differential with respect  
12          to any employee is the amount by which the cost of  
13          the high deductible health plan in which the em-  
14          ployee is enrolled is less than—

15                   “(A) the cost of the health plan (for the  
16                   same class of enrollment) which—

17                           “(i) the employee is eligible to enroll  
18                           in through the employer, and

19                           “(ii) has the highest cost of all health  
20                           plans in which the employee may enroll in  
21                           through the employer, or

22                   “(B) if the employee is not eligible to en-  
23                   roll in any such health plan through the em-  
24                   ployer, the cost of the health plan providing the  
25                   FedMed benefit package.

1           “(4) DEFINITIONS.—For purposes of this sub-  
2       section—

3           “(A) IN GENERAL.—The term ‘FedMed  
4       benefit package’ has the meaning given such  
5       term by section 21115(b) of the Social Security  
6       Act.

7           “(B) HIGH DEDUCTIBLE HEALTH PLAN.—  
8       The term ‘high deductible health plan’ has the  
9       meaning given such term by section 220(c)(2).

10          “(C) MEDICAL SAVINGS ACCOUNT.—The  
11       term ‘medical savings account’ has the meaning  
12       given such term by section 7705.”

13       (b) EMPLOYER PAYMENTS EXCLUDED FROM EM-  
14       PLOYMENT TAX BASE.—

15           (1) SOCIAL SECURITY TAXES.—

16           (A) Subsection (a) of section 3121 is  
17       amended by striking “or” at the end of para-  
18       graph (20), by striking the period at the end of  
19       paragraph (21) and inserting “; or”, and by in-  
20       serting after paragraph (21) the following new  
21       paragraph:

22           “(22) any payment made to or for the benefit  
23       of an employee if at the time of such payment it is  
24       reasonable to believe that the employee will be able

1 to exclude such payment from income under section  
2 106(b).”

3 (B) Subsection (a) of section 209 of the  
4 Social Security Act is amended by striking “or”  
5 at the end of paragraph (18), by striking the  
6 period at the end of paragraph (19) and insert-  
7 ing “; or”, and by inserting after paragraph  
8 (19) the following new paragraph:

9 “(20) any payment made to or for the benefit  
10 of an employee if at the time of such payment it is  
11 reasonable to believe that the employee will be able  
12 to exclude such payment from income under section  
13 106(b) of the Internal Revenue Code of 1986.”

14 (2) RAILROAD RETIREMENT TAX.—Subsection  
15 (e) of section 3231 is amended by adding at the end  
16 the following new paragraph:

17 “(10) MEDICAL SAVINGS ACCOUNT CONTRIBU-  
18 TIONS.—The term ‘compensation’ shall not include  
19 any payment made to or for the benefit of an em-  
20 ployee if at the time of such payment it is reason-  
21 able to believe that the employee will be able to ex-  
22 clude such payment from income under section  
23 106(b).”

24 (3) UNEMPLOYMENT TAX.—Subsection (b) of  
25 section 3306 is amended by striking “or” at the end

1 of paragraph (15), by striking the period at the end  
2 of paragraph (16) and inserting “; or”, and by in-  
3 serting after paragraph (16) the following new para-  
4 graph:

5 “(17) any payment made to or for the benefit  
6 of an employee if at the time of such payment it is  
7 reasonable to believe that the employee will be able  
8 to exclude such payment from income under section  
9 106(b).”

10 (4) WITHHOLDING TAX.—Subsection (a) of sec-  
11 tion 3401 is amended by striking “or” at the end of  
12 paragraph (19), by striking the period at the end of  
13 paragraph (20) and inserting “; or”, and by insert-  
14 ing after paragraph (20) the following new para-  
15 graph:

16 “(21) any payment made to or for the benefit  
17 of an employee if at the time of such payment it is  
18 reasonable to believe that the employee will be able  
19 to exclude such payment from income under section  
20 106(b).”

21 (c) CONFORMING AMENDMENT.—Section 106 is  
22 amended by striking “Gross” and inserting:

23 “(a) GENERAL RULE.—Gross”.

1 (d) EFFECTIVE DATE.—The amendments made by  
 2 this section shall apply to taxable years beginning after  
 3 December 31, 1994.

4 **SEC. 113. MEDICAL SAVINGS ACCOUNTS.**

5 (a) IN GENERAL.—Chapter 79 is amended by adding  
 6 at the end the following new section:

7 **“SEC. 7705. MEDICAL SAVINGS ACCOUNTS.**

8 “(a) GENERAL RULE.—The term ‘medical savings  
 9 account’ means a trust created or organized in the United  
 10 States for the exclusive benefit of the beneficiaries of the  
 11 trust, but only if the written governing instrument creat-  
 12 ing the trust meets the following requirements:

13 “(1) Except in the case of a rollover contribu-  
 14 tion described in subsection (c)(4), no contribution  
 15 will be accepted unless—

16 “(A) it is in cash, and

17 “(B) it is made for a period during which  
 18 the individual on whose behalf it is made is cov-  
 19 ered under a high deductible health plan.

20 “(2) Contributions will not be accepted for any  
 21 calendar year in excess of \$2,000 (\$4,000 in the  
 22 case of an account established on behalf of the indi-  
 23 vidual and the individual’s spouse and dependents).

24 “(3) The trustee is a bank (as defined in sec-  
 25 tion 408(n)), insurance company (as defined in sec-

tion 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

“(4) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

“(5) No part of the trust assets will be invested in life insurance contracts.

“(6) The interest of an individual in the balance in the individual’s account is nonforfeitable.

“(b) TAX TREATMENT OF ACCOUNTS.—

“(1) ACCOUNT TAXED AS GRANTOR TRUST.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), the account beneficiary of a medical savings account shall be treated for purposes of this title as the owner of such account and shall be subject to tax thereon in accordance with subpart E of part I of subchapter J of this chapter (relating to grantors and others treated as substantial owners).

“(B) TREATMENT OF CAPITAL LOSSES.—

With respect to assets held in a medical savings account, any capital loss for a taxable year from the sale or exchange of such an asset shall

1 be allowed only to the extent of capital gains  
2 from such assets for such taxable year. Any  
3 capital loss which is disallowed under the pre-  
4 ceding sentence shall be treated as a capital  
5 loss from the sale or exchange of such an asset  
6 in the next taxable year.

7 “(2) ACCOUNT TERMINATES IF INDIVIDUAL EN-  
8 GAGES IN PROHIBITED TRANSACTION.—

9 “(A) IN GENERAL.—If, during any taxable  
10 year of the account beneficiary, such beneficiary  
11 engages in any transaction prohibited by section  
12 4975 with respect to the account, the account  
13 shall cease to be a medical savings account as  
14 of the first day of such taxable year.

15 “(B) ACCOUNT TREATED AS DISTRIBUTING  
16 ALL ITS ASSETS.—In any case in which any ac-  
17 count ceases to be a medical savings account by  
18 reason of subparagraph (A) on the first day of  
19 any taxable year, subsection (c) shall be applied  
20 as if—

21 “(i) there were a distribution on such  
22 first day in an amount equal to the fair  
23 market value (on such first day) of all as-  
24 sets in the account (on such first day), and



1                   “(ii) no portion of such distribution  
2                   were used to pay qualified medical ex-  
3                   penses.

4                   “(3) EFFECT OF PLEDGING ACCOUNT AS SECUR-  
5                   RITY.—If, during any taxable year, the account ben-  
6                   eficiary uses the account or any portion thereof as  
7                   security for a loan, the portion so used is treated as  
8                   distributed and not used to pay qualified medical ex-  
9                   penses.

10                  “(c) TAX TREATMENT OF DISTRIBUTIONS.—

11                   “(1) INCLUSION OF AMOUNTS NOT USED FOR  
12                   QUALIFIED MEDICAL EXPENSES.—

13                   “(A) IN GENERAL.—Any amount paid or  
14                   distributed out of a medical savings account  
15                   which is not used exclusively to pay the quali-  
16                   fied medical expenses of the account beneficiary  
17                   or of the spouse or dependents of such bene-  
18                   ficiary shall be included in the gross income of  
19                   such beneficiary to the extent such amount does  
20                   not exceed the excess of—

21                   “(i) the aggregate contributions to  
22                   such account which were not includible in  
23                   gross income by reason of section 106(b)  
24                   or which were deductible under section  
25                   220, over

1           “(ii) the aggregate prior payments or  
2           distributions from such account which were  
3           includible in gross income under this para-  
4           graph.

5           “(B) SPECIAL RULES.—For purposes of  
6           subparagraph (A)—

7           “(i) all payments and distributions  
8           during any taxable year shall be treated as  
9           1 distribution, and

10           “(ii) any distribution of property shall  
11           be taken into account at its fair market  
12           value on the date of the distribution.

13           “(2) EXCESS CONTRIBUTIONS RETURNED BE-  
14           FORE DUE DATE OF RETURN.—Paragraph (1) shall  
15           not apply to the distribution of any contribution paid  
16           during a taxable year to a medical savings account  
17           to the extent that such contribution exceeds the  
18           amount under subsection (a)(2) if—

19           “(A) such distribution is received by the  
20           individual on or before the last day prescribed  
21           by law (including extensions of time) for filing  
22           such individual’s return for such taxable year,  
23           and

1           “(B) such distribution is accompanied by  
2           the amount of net income attributable to such  
3           excess contribution.

4           Any net income described in subparagraph (B) shall  
5           be included in the gross income of the individual for  
6           the taxable year in which it is received.

7           “(3) PENALTY FOR DISTRIBUTIONS NOT USED  
8           FOR QUALIFIED MEDICAL EXPENSES.—

9           “(A) IN GENERAL.—The tax imposed by  
10          chapter 1 on the account beneficiary for any  
11          taxable year in which there is a payment or dis-  
12          tribution from a medical savings account of  
13          such beneficiary which is includible in gross in-  
14          come under paragraph (1) shall be increased by  
15          10 percent of the amount which is so includible.

16          “(B) EXCEPTION FOR DISABILITY OR  
17          DEATH.—Subparagraph (A) shall not apply if  
18          the payment or distribution is made after the  
19          account beneficiary becomes disabled within the  
20          meaning of section 72(m)(7) or dies.

21          “(C) EXCEPTION FOR DISTRIBUTIONS  
22          AFTER AGE 59½.—Subparagraph (A) shall not  
23          apply to any payment or distribution after the  
24          date on which the account beneficiary attains  
25          age 59½.

1           “(4) ROLLOVER CONTRIBUTION.—An amount is  
2 described in this paragraph as a rollover contribu-  
3 tion if it meets the requirements of subparagraphs  
4 (A) and (B).

5           “(A) IN GENERAL.—Paragraph (1) shall  
6 not apply to any amount paid or distributed  
7 from a medical savings account to the account  
8 beneficiary to the extent the amount received is  
9 paid into a medical savings account for the ben-  
10 efit of such beneficiary not later than the 60th  
11 day after the day on which the beneficiary re-  
12 ceives the payment or distribution.

13           “(B) LIMITATION.—This paragraph shall  
14 not apply to any amount described in subpara-  
15 graph (A) received by an individual from a  
16 medical savings account if, at any time during  
17 the 1-year period ending on the day of such re-  
18 ceipt, such individual received any other amount  
19 described in subparagraph (A) from a medical  
20 savings account which was not includible in the  
21 individual’s gross income because of the appli-  
22 cation of this paragraph.

23           “(5) COORDINATION WITH MEDICAL EXPENSE  
24 DEDUCTION.—For purposes of section 213, any pay-  
25 ment or distribution out of a medical savings ac-

1 count for qualified medical expenses shall not be  
2 treated as an expense paid for medical care to the  
3 extent of the amount of such payment or distribu-  
4 tion which is excludable from gross income solely by  
5 reason of paragraph (1)(A).

6 “(6) TRANSFER OF ACCOUNT INCIDENT TO DI-  
7 VORCE.—The transfer of an individual’s interest in  
8 a medical savings account to an individual’s spouse  
9 or former spouse under a divorce or separation in-  
10 strument described in subparagraph (A) of section  
11 71(b)(2) shall not be considered a taxable transfer  
12 made by such individual notwithstanding any other  
13 provision of this subtitle, and such interest at the  
14 time of the transfer shall be treated as a medical  
15 savings account of such spouse, and not of such in-  
16 dividual. Any such account or annuity shall, for pur-  
17 poses of this subtitle, be treated as maintained for  
18 the benefit of the spouse to whom the interest was  
19 transferred.

20 “(d) DEFINITIONS.—For purposes of this section—

21 “(1) QUALIFIED MEDICAL EXPENSES.—

22 “(A) IN GENERAL.—The term ‘qualified  
23 medical expenses’ means any expense—

24 “(i) for medical care (as defined in  
25 section 213(d)), or

1 “(ii) for qualified long-term care serv-  
2 ices (as defined in section 213(g)).

3 “(B) EXCEPTION FOR INSURANCE.—

4 “(i) IN GENERAL.—Such term shall  
5 not include any expense for insurance.

6 “(ii) EXCEPTIONS.—Clause (i) shall  
7 not apply to any expense for—

8 “(I) coverage under a qualified  
9 long-term care contract (as defined in  
10 section 7702B(b)),

11 “(II) coverage under a health  
12 plan during a period of continuation  
13 coverage described in section  
14 4980B(f)(2)(B),

15 “(III) coverage under a medicare  
16 supplemental policy (as defined in sec-  
17 tion 1882(g)(1) of the Social Security  
18 Act), or

19 “(IV) payment of premiums  
20 under part A or B of title XVIII of  
21 the Social Security Act.

22 “(2) ACCOUNT BENEFICIARY.—The term ‘ac-  
23 count beneficiary’ means the individual for whose  
24 benefit the medical savings account is maintained.

1       “(e) CUSTODIAL ACCOUNTS.—For purposes of this  
2 section, a custodial account shall be treated as a trust if—

3               “(1) the assets of such account are held by a  
4 bank (as defined in section 408(n)), insurance com-  
5 pany (as defined in section 816), or another person  
6 who demonstrates to the satisfaction of the Sec-  
7 retary that the manner in which such person will ad-  
8 minister the account will be consistent with the re-  
9 quirements of this section, and

10              “(2) the custodial account would, except for the  
11 fact that it is not a trust, constitute a medical sav-  
12 ings account described in subsection (a).

13 For purposes of this title, in the case of a custodial ac-  
14 count treated as a trust by reason of the preceding sen-  
15 tence, the custodian of such account shall be treated as  
16 the trustee thereof.

17       “(f) REPORTS.—The trustee of a medical savings ac-  
18 count shall make such reports regarding such account to  
19 the Secretary and to the individual for whose benefit the  
20 account is maintained with respect to contributions, dis-  
21 tributions, and such other matters as the Secretary may  
22 require under regulations. The reports required by this  
23 subsection shall be filed at such time and in such manner  
24 and furnished to such individuals at such time and in such  
25 manner as may be required by those regulations.”

1 (b) TAX ON EXCESS CONTRIBUTIONS.—Section 4973  
 2 (relating to tax on excess contributions to individual re-  
 3 tirement accounts, certain section 403(b) contracts, and  
 4 certain individual retirement annuities) is amended—

5 (1) by inserting “**MEDICAL SAVINGS AC-**  
 6 **COUNTS,**” after “**ACCOUNTS,**” in the heading of  
 7 such section,

8 (2) by striking “or” at the end of paragraph  
 9 (1) of subsection (a),

10 (3) by redesignating paragraph (2) of sub-  
 11 section (a) as paragraph (3) and by inserting after  
 12 paragraph (1) the following:

13 “(2) a medical savings account (within the  
 14 meaning of section 7705(a)), or”, and

15 (4) by adding at the end the following new sub-  
 16 section:

17 “(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS  
 18 ACCOUNTS.—For purposes of this section, in the case of  
 19 a medical savings account (within the meaning of section  
 20 7705(a)), the term ‘excess contributions’ means the  
 21 amount by which the amount contributed for the taxable  
 22 year to the account exceeds the amount which may be con-  
 23 tributed to the account under section 7705(a)(2) for such  
 24 taxable year. For purposes of this subsection, any con-  
 25 tribution which is distributed out of the medical savings



1 account in a distribution to which section 7705(c)(2) ap-  
2 plies shall be treated as an amount not contributed.”

3 (c) TAX ON PROHIBITED TRANSACTIONS.—Section  
4 4975 (relating to prohibited transactions) is amended—

5 (1) by adding at the end of subsection (c) the  
6 following new paragraph:

7 “(4) SPECIAL RULE FOR MEDICAL SAVINGS AC-  
8 COUNTS.—An individual for whose benefit a medical  
9 savings account (within the meaning of section  
10 7705(a)) is established shall be exempt from the tax  
11 imposed by this section with respect to any trans-  
12 action concerning such account (which would other-  
13 wise be taxable under this section) if, with respect  
14 to such transaction, the account ceases to be a medi-  
15 cal savings account by reason of the application of  
16 section 7705(b)(2)(A) to such account.”, and

17 (2) by inserting “or a medical savings account  
18 described in section 7705(a)” in subsection (e)(1)  
19 after “described in section 408(a)”.

20 (d) FAILURE TO PROVIDE REPORTS ON MEDICAL  
21 SAVINGS ACCOUNTS.—Section 6693 (relating to failure to  
22 provide reports on individual retirement accounts or annu-  
23 ities) is amended—

1 (1) by inserting “**OR ON MEDICAL SAVINGS**  
 2 **ACCOUNTS**” after “**ANNUITIES**” in the heading of  
 3 such section, and

4 (2) by adding at the end of subsection (a) the  
 5 following: “The person required by section 7705(f)  
 6 to file a report regarding a medical savings account  
 7 at the time and in the manner required by such sec-  
 8 tion shall pay a penalty of \$50 for each failure un-  
 9 less it is shown that such failure is due to reasonable  
 10 cause.”

11 (e) CLERICAL AMENDMENTS.—

12 (1) The table of sections for chapter 43 is  
 13 amended by striking the item relating to section  
 14 4973 and inserting the following:

“Sec. 4973. Tax on excess contributions to individual retirement  
 accounts, medical savings accounts, certain 403(b)  
 contracts, and certain individual retirement annu-  
 ities.”

15 (2) The table of sections for subchapter B of  
 16 chapter 68 is amended by inserting “or on medical  
 17 savings accounts” after “annuities” in the item re-  
 18 lating to section 6693.

## 19 **Subtitle B—Premium Assistance**

### 20 **SEC. 121. PREMIUM ASSISTANCE.**

21 (a) MEDICAID STATE PLAN REQUIREMENT.—Section  
 22 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)),  
 23 as amended by section 201(a), is amended—

1 (1) by striking “and” at the end of paragraph  
2 (62);

3 (2) by striking the period at the end of para-  
4 graph (63) and inserting “; and”; and

5 (3) by adding at the end the following new  
6 paragraph:

7 “(64) provide for a State program furnishing  
8 premium assistance in accordance with part B.”.

9 (b) STATE PROGRAMS FOR PREMIUM ASSISTANCE.—  
10 Title XIX of the Social Security Act (42 U.S.C. 1396 et  
11 seq.) is amended by adding at the end the following new  
12 part:

13 **“PART B—STATE PROGRAMS FOR PREMIUM**  
14 **ASSISTANCE**

15 **“Subpart 1—Establishment of Premium Assistance**  
16 **Programs**

17 **“SEC. 1951. REQUIREMENT TO OPERATE STATE PROGRAM.**

18 “(a) IN GENERAL.—A State with a State plan ap-  
19 proved under part A shall have in effect a program for  
20 furnishing premium assistance under section 1952 to fam-  
21 ilies with incomes below certain income thresholds in cal-  
22 endar years beginning after 1996.

23 “(b) DESIGNATION OF STATE AGENCY.—A State  
24 may designate any appropriate State agency to administer  
25 the program under this part.

1   **“SEC. 1952. ASSISTANCE WITH CERTIFIED HEALTH PLAN**  
2                   **PREMIUMS.**

3           “(a) ELIGIBILITY.—

4                   “(1) IN GENERAL.—A family (as defined in sec-  
5           tion 1957(4)) which has been determined by a State  
6           under section 1953 to be a premium subsidy eligible  
7           family (as defined in paragraph (2)) shall be entitled  
8           to premium assistance in the amount determined  
9           under subsection (b).

10           “(2) PREMIUM SUBSIDY ELIGIBLE FAMILY.—

11                   “(A) IN GENERAL.—For purposes of this  
12           part, the term ‘premium subsidy eligible family’  
13           means a family which has a family income de-  
14           termined under section 1957(2) which does not  
15           exceed 150 percent of the poverty line (as de-  
16           fined in section 1957(5)).

17                   “(B) REDUCTION IN ELIGIBILITY PER-  
18           CENTAGE.—For requirement that the President  
19           reduce the percentage of the poverty line appli-  
20           cable to family income under subparagraph (A),  
21           see subpart 2.

22           “(b) AMOUNT OF ASSISTANCE.—

23                   “(1) IN GENERAL.—Except as provided in para-  
24           graph (4), the amount of premium assistance for a  
25           month for a premium subsidy eligible family is the  
26           lesser of—

1           “(A) the subsidy percentage specified in  
2 paragraph (3) multiplied by  $\frac{1}{12}$ th of the annual  
3 premium for coverage under the certified health  
4 plan in which the family is enrolled, or

5           “(B) the subsidy percentage specified in  
6 paragraph (3) multiplied by  $\frac{1}{12}$ th of the maxi-  
7 mum subsidy amount for the year for the fam-  
8 ily (determined under paragraph (2)).

9           “(2) MAXIMUM SUBSIDY AMOUNT.—

10           “(A) IN GENERAL.—The maximum subsidy  
11 amount determined under this paragraph for a  
12 year for a family is the maximum subscription  
13 charge for the family’s class of enrollment  
14 under all health benefits plans offered under  
15 chapter 89 of title 5, United States Code for  
16 the year, as adjusted under subparagraph (B).

17           “(B) ADJUSTMENTS.—The Secretary shall  
18 adjust the maximum subscription charge for a  
19 family determined under subparagraph (A) by  
20 the age adjustment factors specified under sec-  
21 tion 21114(b)(2)(C) and for geographic dif-  
22 ferences in health care costs based on the com-  
23 munity rating area in which the family resides.

24           “(3) SUBSIDY PERCENTAGE.—

1           “(A) IN GENERAL.—Except as provided in  
2           subparagraph (B), the term ‘subsidy percent-  
3           age’ means—

4                   “(i) 100 percent if the family income  
5                   does not exceed 100 percent of the poverty  
6                   line;

7                   “(ii) 90 percent if the family income  
8                   exceeds 100 percent of the poverty line but  
9                   does not exceed 110 percent of the poverty  
10                  line;

11                  “(iii) 80 percent if the family income  
12                  exceeds 110 percent of the poverty line but  
13                  does not exceed 115 percent of the poverty  
14                  line;

15                  “(iv) 70 percent if the family income  
16                  exceeds 115 percent of the poverty line but  
17                  does not exceed 125 percent of the poverty  
18                  line;

19                  “(v) 60 percent if the family income  
20                  exceeds 120 percent of the poverty line but  
21                  does not exceed 125 percent of the poverty  
22                  line;

23                  “(vi) 50 percent if the family income  
24                  exceeds 125 percent of the poverty line but

1 does not exceed 130 percent of the poverty  
2 line;

3 “(vii) 40 percent if the family income  
4 exceeds 130 percent of the poverty line but  
5 does not exceed 135 percent of the poverty  
6 line;

7 “(viii) 30 percent if the family income  
8 exceeds 135 percent of the poverty line but  
9 does not exceed 140 percent of the poverty  
10 line;

11 “(ix) 20 percent if the family income  
12 exceeds 140 percent of the poverty line but  
13 does not exceed 145 percent of the poverty  
14 line; and

15 “(x) 10 percent if the family income  
16 exceeds 145 percent of the poverty line but  
17 does not exceed 150 percent of the poverty  
18 line.

19 “(B) SPECIAL RULES.—

20 “(i) AFDC RECIPIENTS.—For a family  
21 receiving aid to families with dependent  
22 children under part A or E of title IV, the  
23 subsidy percentage shall be 100 percent.

24 “(ii) NON-CASH MEDICAID ELIGI-  
25 BLES.—For a family that would have been

1 eligible for medical assistance under the  
2 State plan under part A under the eligi-  
3 bility rules in effect in the year preceding  
4 the first year the State began integrating  
5 individuals into the premium assistance  
6 program under this part in accordance  
7 with section 1932(a), the subsidy percent-  
8 age shall be 100 percent.

9 “(C) REDUCTION IN SUBSIDY PERCENT-  
10 AGE.—For requirement that the President re-  
11 duce the subsidy percentages under subpara-  
12 graph (A), see subpart 2.

13 “(c) PAYMENTS.—

14 “(1) IN GENERAL.—The amount of the pre-  
15 mium assistance available to a premium subsidy eli-  
16 gible family under subsection (b) shall be paid by  
17 the State directly to the certified health plan in  
18 which the family is enrolled. Payments under the  
19 preceding sentence shall commence in the first  
20 month during which the family is enrolled in a cer-  
21 tified health plan and determined under section  
22 1953 to be a premium subsidy eligible family.

23 “(2) ADMINISTRATIVE ERRORS.—A State is fi-  
24 nancially responsible for premium assistance paid  
25 based on an eligibility determination error to the ex-



1       tent the State's error rate for eligibility determina-  
2       tions exceeds a maximum permissible error rate to  
3       be specified by the Secretary.

4   **“SEC. 1953. ELIGIBILITY DETERMINATIONS.**

5       “(a) IN GENERAL.—The Secretary shall promulgate  
6       regulations specifying requirements for State programs  
7       under this part with respect to determining eligibility for  
8       premium assistance, including requirements with respect  
9       to—

10               “(1) application procedures;

11               “(2) information verification procedures;

12               “(3) timeliness of eligibility determinations;

13               “(4) procedures for applicants to appeal adverse  
14       decisions; and

15               “(5) any other matters determined appropriate  
16       by the Secretary.

17       “(b) SPECIFICATIONS FOR REGULATIONS.—The reg-  
18       ulations promulgated by the Secretary under subsection  
19       (a) shall include the following requirements:

20               “(1) APPLICATIONS.—A State program shall  
21       provide that a family may file an application for as-  
22       sistance with an agency designated by the State at  
23       any time, in person or by mail.

1           “(2) APPLICATION FORM.—A State program  
2       shall provide for the use of an application form de-  
3       veloped by the Secretary under subsection (c).

4           “(3) DISTRIBUTION OF APPLICATIONS.—A  
5       State program shall make available applications for  
6       assistance through employers and appropriate public  
7       agencies or organizations.

8           “(4) DISTRIBUTION OF INFORMATION ON CER-  
9       TIFIED HEALTH PLANS.—A State program shall pro-  
10      vide that each family applying for assistance under  
11      this part receives the information determined appro-  
12      priate by the Secretary on each certified health plan  
13      providing the FedMed benefits package as described  
14      in section 21115(b) offered in the community rating  
15      area in which the family resides.

16          “(5) REQUIREMENT TO SUBMIT REVISED AP-  
17      PLICATION.—A State program shall, in accordance  
18      with regulations promulgated by the Secretary, re-  
19      quire families to submit revised applications during  
20      a year to reflect increases in estimated family in-  
21      comes during the year. The State shall revise the  
22      amount of any premium assistance based on such a  
23      revised application.

24          “(6) AFDC APPLICANTS.—A State program  
25      shall include a procedure under which families ap-

1       plying for benefits under title IV shall have an op-  
2       portunity to apply for assistance under this part in  
3       connection with such application.

4               “(7) VERIFICATION.—A State program shall  
5       provide for verification of the information supplied  
6       in applications under this part.

7       “(c) ADMINISTRATION OF STATE PROGRAMS.—

8               “(1) IN GENERAL.—The Secretary shall estab-  
9       lish standards for States operating programs under  
10      this part which ensure that such programs are oper-  
11      ated in a uniform manner with respect to application  
12      procedures, data processing systems, and such other  
13      administrative activities as the Secretary determines  
14      to be necessary.

15              “(2) APPLICATION FORMS.—The Secretary  
16      shall develop a standard application form for assist-  
17      ance which shall—

18                      “(A) be simple in form and understandable  
19                      to the average individual;

20                      “(B) require the provision of information  
21                      necessary to make a determination as to wheth-  
22                      er a family is a premium subsidy eligible family  
23                      including a declaration of estimated income by  
24                      the family based, at the election of the family—

1 “(i) on multiplying by a factor of 4  
 2 the family’s family income for the 3-month  
 3 period immediately preceding the month in  
 4 which the application is made, or

5 “(ii) on estimated income for the en-  
 6 tire year for which the application is sub-  
 7 mitted; and

8 “(C) require attachment of such docu-  
 9 mentation as deemed necessary by the Sec-  
 10 retary in order to ensure eligibility for assist-  
 11 ance.

12 “(d) EFFECTIVENESS OF ELIGIBILITY FOR PREMIUM  
 13 SUBSIDIES.—A determination by a State that a family is  
 14 a premium subsidy eligible family shall be effective for the  
 15 calendar year for which such determination is made unless  
 16 a revised application submitted under subsection (b)(5) in-  
 17 dicates that a family is no longer eligible for premium as-  
 18 sistance.

19 **“SEC. 1954. END-OF-YEAR RECONCILIATION FOR PREMIUM**  
 20 **ASSISTANCE.**

21 “(a) IN GENERAL.—

22 “(1) REQUIREMENT TO FILE STATEMENT.—A  
 23 family which received premium assistance under this  
 24 part from a State for any month in a calendar year  
 25 shall file with the State an income reconciliation

1 statement to verify the family's family income for  
2 the year. Such a statement shall be filed at such  
3 time, and contain such information, as the State  
4 may specify in accordance with regulations promul-  
5 gated by the Secretary.

6 “(2) NOTICE OF REQUIREMENT.—A State shall  
7 provide a written notice of the requirement under  
8 paragraph (1) at the time a family submits an appli-  
9 cation for premium assistance under this part and at  
10 the end of the year to a family which received such  
11 assistance from such State in any month during the  
12 year.

13 “(b) RECONCILIATION OF PREMIUM ASSISTANCE  
14 BASED ON ACTUAL INCOME.—

15 “(1) IN GENERAL.—Based on and using the in-  
16 come reported in the reconciliation statement filed  
17 under subsection (a) with respect to a family, the  
18 State shall compute the amount of premium assist-  
19 ance that should have been provided under this part  
20 with respect to the family for the year involved.

21 “(2) OVERPAYMENT OF ASSISTANCE.—If the  
22 total amount of the premium assistance provided  
23 was greater than the amount computed under para-  
24 graph (1), the family is liable to the State to pay an  
25 amount equal to the amount of the excess payment.

1 Any amount collected by a State under this para-  
2 graph shall be submitted to the Secretary in a timely  
3 manner.

4 “(3) STATE OPTION.—A State may, in accord-  
5 ance with regulations promulgated by the Secretary,  
6 establish a procedure under which any overpayments  
7 of premium assistance determined under paragraph  
8 (2) with respect to a family for a year may be col-  
9 lected or paid, as appropriate, through adjustments  
10 to the premium assistance furnished to such family  
11 in the succeeding year.

12 “(c) VERIFICATION.—Each State may use such infor-  
13 mation as it has available to verify income of families with  
14 applications filed under this part.

15 “(d) PENALTIES FOR FAILURE TO FILE.—In the  
16 case of a family which is required to file a statement under  
17 this section in a year who fails to file such a statement  
18 by such date as the Secretary shall specify in regulations,  
19 the entire amount of the premium assistance provided in  
20 such year shall be considered an excess amount under sub-  
21 section (b)(2) and such family shall not be eligible for pre-  
22 mium assistance under this part until such statement is  
23 filed. A State, using rules established by the Secretary,  
24 shall waive the application of this subsection if the family  
25 establishes, to the satisfaction of the State under such

1 rules, good cause for the failure to file the statement on  
2 a timely basis.

3 **“SEC. 1955. PENALTIES FOR MATERIAL MISREPRESENTA-**  
4 **TION AND FALSE INFORMATION.**

5 “(a) IN GENERAL.—Any individual who knowingly  
6 makes a material misrepresentation of information or pro-  
7 vides false information in an application for assistance  
8 under this part under section 1953 or an income reconcili-  
9 ation statement under section 1954 shall be liable to the  
10 Federal Government for the amount any premium assist-  
11 ance received by the individual on the basis of such mis-  
12 representation or false information and interest on such  
13 amount at a rate specified by the Secretary, and shall,  
14 in addition, be liable to the Federal Government for  
15 \$2,000 or, if greater, 3 times the amount of any premium  
16 assistance received by the individual on the basis of such  
17 misrepresentation or false information.

18 “(b) COLLECTION OF PENALTY AMOUNTS.—A State  
19 which receives an application for assistance or an income  
20 reconciliation statement with respect to which a material  
21 misrepresentation has been made or false information has  
22 been provided shall collect the penalty amount required  
23 under subsection (a) and submit 50 percent of such  
24 amount to the Secretary in a timely manner.

1 **“SEC. 1956. PAYMENTS TO STATES.**

2 “(a) IN GENERAL.—

3 “(1) PAYMENTS FOR PREMIUM ASSISTANCE.—A  
4 State operating a program for furnishing premium  
5 assistance under this part shall be entitled to receive  
6 payments in an amount equal to the amount of pre-  
7 mium assistance paid on behalf of premium subsidy  
8 eligible families. Such payments shall be made at  
9 such time and in such form as provided in regula-  
10 tions promulgated by the Secretary.

11 “(2) MATCHING PAYMENTS FOR ADMINISTRA-  
12 TIVE EXPENSES.—The Secretary shall pay to each  
13 State operating a program for furnishing premium  
14 assistance under this part, for each quarter begin-  
15 ning with the quarter commencing January 1, 1997,  
16 an amount equal to 50 percent of the total amount  
17 expended by the State during the quarter as found  
18 necessary by the Secretary for the proper and effi-  
19 cient administration of the program.

20 “(3) STATE ENTITLEMENT.—This subsection  
21 constitutes budget authority in advance of appro-  
22 priations Acts, and represents the obligation of the  
23 Federal Government to provide payments to States  
24 operating programs under this part in accordance  
25 with this subsection.



1       “(b) FUNDING.—The amount paid to States under  
 2 subsection (a) shall be paid by the Secretary from out of  
 3 any funds in the Treasury of the United States not other-  
 4 wise appropriated.

5       “(c) AUDITS.—The Secretary shall conduct regular  
 6 audits of the activities under the State programs con-  
 7 ducted under this part.

8       **“SEC. 1957. DEFINITIONS AND DETERMINATIONS OF IN-**  
 9                               **COME.**

10       “For purposes of this part:

11               “(1) CERTIFIED HEALTH PLAN.—The term  
 12 ‘certified health plan’ means a certified health plan  
 13 (within the meaning of section 21003(b)) providing  
 14 the FedMed benefits package as described in section  
 15 21115(b).

16               “(2) DETERMINATIONS OF INCOME.—

17                       “(A) IN GENERAL.—The term ‘income’  
 18 means adjusted gross income (as defined in sec-  
 19 tion 62(a) of the Internal Revenue Code of  
 20 1986)—

21                               “(i) determined without regard to sec-  
 22 tions 135, 162(l), 911, 931, and 933 of  
 23 such Code; and

24                               “(ii) increased by—

1           “(I) the amount of interest re-  
2           ceived or accrued which is exempt  
3           from tax, plus

4           “(II) the amount of social secu-  
5           rity benefits (described in section  
6           86(d) of such Code) which is not in-  
7           cludible in gross income under section  
8           86 of such Code.

9           “(B) FAMILY INCOME.—The term ‘family  
10          income’ means, with respect to a family, the  
11          sum of the income for all members of the fam-  
12          ily, not including the income of a dependent  
13          child with respect to which no return is re-  
14          quired under the Internal Revenue Code of  
15          1986.

16          “(3) ELIGIBLE INDIVIDUAL.—

17               “(A) IN GENERAL.—The term ‘eligible in-  
18          dividual’ means an individual who is residing in  
19          the United States and who is—

20                   “(i) a citizen or national of the United  
21                  States; or

22                   “(ii) a lawful alien (as defined in sub-  
23                  paragraph (C)).

24               “(B) EXCLUSIONS.—The term ‘eligible in-  
25          dividual’ shall not include—

1           “(i) an individual who is eligible for  
2           medical assistance under part A consisting  
3           of acute medical services described in sec-  
4           tion 1931(b)(1);

5           “(ii) an individual who is entitled to  
6           benefits under part A of title XVIII;

7           “(iii) an individual with respect to  
8           whom an employer contribution toward the  
9           premium for coverage under the certified  
10          health plan in which the individual is en-  
11          rolled is paid (or offered to be paid) on be-  
12          half of such individual; and

13          “(iv) an individual who is an inmate  
14          of a public institution (except as a patient  
15          of a medical institution).

16          “(C) LAWFUL ALIEN.—The term ‘lawful  
17          alien’ means an individual who is—

18               “(i) an alien lawfully admitted for  
19               permanent residence,

20               “(ii) an asylee,

21               “(iii) a refugee,

22               “(iv) an alien whose deportation has  
23               been withheld under section 243(h) of the  
24               Immigration and Nationality Act, or

1                   “(v) a parolee who has been paroled  
2                   for a period of 1 year or more.

3                   “(4) FAMILY.—The term ‘family’—

4                   “(A) means, with respect to an eligible in-  
5                   dividual who is not a child, the individual; and

6                   “(B) includes the following persons (if  
7                   any):

8                   “(i) The individual’s spouse if the  
9                   spouse is an eligible individual.

10                  “(ii) The individual’s children (and, if  
11                  applicable, the children of the individual’s  
12                  spouse) if they are eligible individuals.

13                  “(5) POVERTY LINE.—The term ‘poverty line’  
14                  means the income official poverty line (as defined by  
15                  the Office of Management and Budget, and revised  
16                  annually in accordance with section 673(2) of the  
17                  Omnibus Budget Reconciliation Act of 1981) that—

18                  “(A) in the case of a family of less than  
19                  five individuals, is applicable to a family of the  
20                  size involved; and

21                  “(B) in the case of a family of more than  
22                  four individuals, is applicable to a family of  
23                  four persons.

1   **“Subpart 2—Deficit Neutral Spending on Premium**  
 2                                   **Assistance**

3   **“SEC. 1960. ENSURING DEFICIT NEUTRAL SPENDING ON**  
 4                                   **PREMIUM ASSISTANCE.**

5       “(a) LIMITATION ON PREMIUM ASSISTANCE SPEND-  
 6   ING.—In each fiscal year (beginning with 1996), spending  
 7   for premium assistance shall be limited to the excess of—

8               “(1) the aggregate limitation described in sub-  
 9       section (b), over

10              “(2) mandatory expenditures under title XVIII  
 11       and part A of XIX, including any offsetting receipts  
 12       required under title XVIII but excluding any discre-  
 13       tionary expenditures under such title or part A of  
 14       title XIX.

15       “(b) AGGREGATE LIMITATION.—

16              “(1) IN GENERAL.—For purposes of this sec-  
 17       tion the aggregate limitation shall be—

18                      “(A) for fiscal year 1996, \$282 billion

19                      “(B) for fiscal year 1997, \$311 billion

20                      “(C) for fiscal year 1998, \$341 billion

21                      “(D) for fiscal year 1999, \$381 billion

22                      “(E) for fiscal year 2000, \$421 billion

23                      “(F) for fiscal year 2001, \$466 billion

24                      “(G) for fiscal year 2002, \$518 billion

25                      “(H) for fiscal year 2003, \$576 billion

26                      “(I) for fiscal year 2004, \$640 billion; and

1           “(J) for fiscal year 2005 and succeeding  
2           fiscal years, the amount in the preceding fiscal  
3           year increased by the growth in the per capita  
4           Gross Domestic Product.

5           “(2) ADJUSTMENT BASED ON MID-SESSION RE-  
6           VIEW OF ESTIMATES.—If it is determined under the  
7           mid-session review of estimates under subsection (d)  
8           that expenditures under the provisions of title  
9           XVIII, part A of title XIX, and the premium assist-  
10          ance program under subpart 1 for the preceding fis-  
11          cal year exceeded the estimates for such fiscal year  
12          then the amount under paragraph (1) for the up-  
13          coming fiscal year shall be decreased by the amount  
14          of such excess.

15          “(c) PRESIDENT’S BUDGET TO INCLUDE PREMIUM  
16          ASSISTANCE ESTIMATES.—

17               “(1) IN GENERAL.—When the President sub-  
18          mits a budget (as required by section 1105 of title  
19          31), the President shall include in such budget—

20                   “(A) estimates of expenditures under the  
21                  provisions of title XVIII, part A of title XIX,  
22                  and the premium assistance program under  
23                  subpart 1 otherwise provided under such provi-  
24                  sions without regard to this section; and

1           “(B) a comparison of the total of such ex-  
 2           penditures with the aggregate limitation estab-  
 3           lished under subsection (b); and

4           “(C) estimates of the income eligibility  
 5           amount (described in subsection (d)(1)) and  
 6           subsidy percentages (described in subsection  
 7           (d)(3)) under the premium assistance program  
 8           that are necessary to comply with enforcement  
 9           of the limitation on premium assistance spend-  
 10          ing under subsection (d).

11          “(2) FISCAL YEARS COVERED.—The President  
 12          shall submit such estimates for the upcoming fiscal  
 13          year and the following 4 fiscal years beginning with  
 14          the budget submitted for fiscal year 1996, and

15               “(A) beginning with the budget for fiscal  
 16               year 1997, the current fiscal year; and

17               “(B) beginning with the budget for fiscal  
 18               year 1998, the current fiscal year and the pre-  
 19               ceding fiscal year.

20          “(d) ENFORCING THE LIMITATION ON PREMIUM AS-  
 21          SISTANCE SPENDING.—

22               “(1) MID-SESSION REVIEW ESTIMATES.—As  
 23               part the President’s supplemental summary provid-  
 24               ing revised estimates of the budget (commonly called  
 25               the ‘mid-session review of the budget’), the Presi-

1       dent shall issue estimates of expenditures under title  
2       XVIII, part A of XIX, and the premium assistance  
3       program under subpart 1 otherwise provided without  
4       regard to this section for—

5               “(A) the upcoming fiscal year;

6               “(B) the current fiscal year (beginning  
7       with the mid-session review for the fiscal year  
8       1997 budget); and

9               “(C) the preceding fiscal year (beginning  
10      with the mid-session review for the fiscal year  
11      1998 budget).

12       “(2) MAXIMUM INCOME ELIGIBILITY.—Based  
13      on the estimates provided pursuant to paragraph  
14      (1), the Director of the Office of Management and  
15      Budget (referred to in this section as the “Direc-  
16      tor”) shall, after consultation with the Secretary, de-  
17      termine the maximum income amount (expressed as  
18      a percentage of the poverty line (as defined in sec-  
19      tion 1957(5))) under which families may be eligible  
20      for premium assistance in the next calendar year  
21      such that spending for premium assistance in the  
22      upcoming fiscal year does not exceed the limitation  
23      established under subsection (b), except that the Di-  
24      rector shall not establish a maximum income amount



1 for the next calendar year that is below such amount  
 2 for the current calendar year.

3 “(3) OTHER MODIFICATIONS.—If maintaining  
 4 the maximum income amount at the level that ap-  
 5 plies in the current calendar year in the next cal-  
 6 endar year would cause spending to exceed the limi-  
 7 tation for premium assistance in the upcoming fiscal  
 8 year, the Director shall order a uniform percentage  
 9 reduction in the subsidy percentages specified under  
 10 section 1952(a)(3) to ensure spending does not ex-  
 11 ceed the limitation.”.

12 (c) CONFORMING AMENDMENTS.—(1) Title XIX of  
 13 the Social Security Act (42 U.S.C. 1396 et seq.) is amend-  
 14 ed by striking the title and inserting the following:

15 **“TITLE XIX—MEDICAL ASSIST-**  
 16 **ANCE PROGRAMS AND STATE**  
 17 **PROGRAMS FOR PREMIUM**  
 18 **ASSISTANCE**

19 **“PART A—GRANTS TO STATES FOR MEDICAL**  
 20 **ASSISTANCE PROGRAMS”.**

21 (2) Title XIX of the Social Security Act (42 U.S.C.  
 22 1396 et seq.) is amended by striking each reference to  
 23 “this title” and inserting “this part”.

1 **TITLE II—HEALTH INSURANCE**  
 2 **AND DELIVERY SYSTEMS RE-**  
 3 **FORM**

4 **Subtitle A—Federal Standards for**  
 5 **State Certification Programs**

6 **SEC. 201. STATE PLAN FOR CERTIFICATION OF HEALTH IN-**  
 7 **SURANCE AND DELIVERY SYSTEMS.**

8 (a) MEDICAID STATE PLAN REQUIREMENT.—Section  
 9 1902(a) of the Social Security Act (42 U.S.C. 1396a(a))  
 10 is amended by striking “and” at the end of paragraph  
 11 (61), by striking the period at the end of paragraph (62)  
 12 and inserting “; and”, and by inserting after paragraph  
 13 (62) the following new paragraph:

14 “(63) provide that the State is a participating State  
 15 under title XXI.”

16 (b) PARTICIPATING STATE PLAN FOR CERTIFI-  
 17 CATION OF HEALTH INSURANCE AND DELIVERY SYS-  
 18 TEMS.—The Social Security Act is amended by adding at  
 19 the end the following new title:

20 **“TITLE XXI—STATE PLAN FOR**  
 21 **CERTIFICATION OF HEALTH**  
 22 **INSURANCE AND DELIVERY**  
 23 **SYSTEMS**

24 “TABLE OF CONTENTS

“Subtitle A—Participating State Program

“PART I—GENERAL RESPONSIBILITIES

- “Sec. 21001. Establishment of participating State programs.
- “Sec. 21002. Access to standardized health care coverage.
- “Sec. 21003. General definitions relating to health plans.

“PART II—CERTIFICATION AND CONSUMER VALUE

- “Sec. 21011. Certification of health plans.
- “Sec. 21012. Consumer value program.
- “Sec. 21013. Establishment of community rating areas.
- “Sec. 21014. Risk adjustment programs.
- “Sec. 21015. Specification of initial general enrollment period.

“PART III—TREATMENT OF CERTAIN STATE LAWS

- “Sec. 21021. Preemption of certain State law restrictions on health plans.
- “Sec. 21022. Preemption from State benefit mandates.
- “Sec. 21023. Preemption of State law regulating utilization management and review.
- “Sec. 21024. State laws regarding end of life treatment.

“PART IV—DEFINITIONS AND RULES

- “Sec. 21100. Definitions and rules of general application.

“Subtitle B—Standards for Reform

“PART I—ESTABLISHMENT AND APPLICATION OF STANDARDS AND GUIDELINES

- “Sec. 21101. Insurance reform standards.
- “Sec. 21102. Delivery system guidelines.
- “Sec. 21103. Consumer value program.
- “Sec. 21104. Risk adjustment programs.
- “Sec. 21105. Standards and guidelines by Secretary of Labor.
- “Sec. 21106. General rules.

“PART II—INSURANCE REFORM STANDARDS APPLICABLE TO HEALTH PLANS

- “Sec. 21111. Guaranteed issue and renewal.
- “Sec. 21112. Enrollment.
- “Sec. 21113. Nondiscrimination based on health status.
- “Sec. 21114. Rating limitations for community-rated market.
- “Sec. 21115. Benefits offered.
- “Sec. 21116. Risk adjustment.
- “Sec. 21117. Prohibition of discrimination.

“PART III—MINIMUM DELIVERY SYSTEM GUIDELINES APPLICABLE TO HEALTH PLANS

- “Sec. 21121. Minimum delivery system guidelines.

“Subtitle C—Expanded Access to Health Plans

“PART I—ACCESS THROUGH HEALTH INSURANCE PURCHASING COOPERATIVES

- “Sec. 21201. Establishment and organization.

“PART II—ACCESS THROUGH FEHBP

“Sec. 21211. Small business participation in FEHBP.

“PART III—ACCESS THROUGH ASSOCIATION PLANS

“SUBPART A—QUALIFIED ASSOCIATION PLANS

“Sec. 21221. Treatment of qualified association plans.

“Sec. 21222. Qualified association plan defined.

“Sec. 21223. Definitions and special rules.

“SUBPART B—SPECIAL RULE FOR CHURCH, MULTIEMPLOYER, AND  
COOPERATIVE PLANS

“Sec. 21225. Special rule for church, multiemployer, and cooperative plans.

“PART IV—ACCESS THROUGH EMPLOYERS

“Sec. 21231. General employer responsibilities.

“Sec. 21232. Development of large employer purchasing groups.

“Sec. 21233. Report to employees on employer health care contributions.

“Sec. 21334. Employer may not discriminate against subsidy eligible individuals.

“Sec. 21235. Enforcement.

1     **“Subtitle A—Participating State**  
2                             **Program**

3             **“PART I—GENERAL RESPONSIBILITIES**

4     **“SEC. 21001. ESTABLISHMENT OF PARTICIPATING STATE**  
5                             **PROGRAMS.**

6             “A State shall be a participating State for purposes  
7 of this title if such State establishes by not later than Jan-  
8 uary 1, 1998, a certification and consumer value program  
9 (in this title referred to as a ‘State program’) to carry  
10 out participating State responsibilities specified in this  
11 title.

12     **“SEC. 21002. ACCESS TO STANDARDIZED HEALTH CARE**  
13                             **COVERAGE.**

14             “(a) ACCESS TO STANDARDIZED COVERAGE.—

1           “(1) IN GENERAL.—Except as provided in para-  
 2           graph (2), a State program shall require that each  
 3           insured health plan issued, sold, offered for sale, or  
 4           operated in the State shall be certified by the appro-  
 5           priate certifying authority as a certified health plan.

6           “(2) FEDERAL CERTIFICATION OF SELF-IN-  
 7           SURED PLANS.—In the case of self-insured health  
 8           plans, the Secretary of Labor shall carry out activi-  
 9           ties under this title in the same manner as a partici-  
 10          pating State would carry out such activities with re-  
 11          spect to an insured health plan subject to this title.

12          “(b) ACCESS TO AFFORDABLE COVERAGE.—A State  
 13          program shall require the following:

14               “(1) COMMUNITY RATING.—

15                   “(A) IN GENERAL.—Except as provided in  
 16                   subparagraph (B), all health plans shall be  
 17                   community-rated health plans which cover only  
 18                   community-rated individuals.

19                   “(B)     EXPERIENCE-RATED     HEALTH  
 20                   PLANS.—Subparagraph (A) shall not apply to  
 21                   any health plan which—

22                           “(i) is a self-insured health plan of an  
 23                           experience-rated employer, or

24                           “(ii) is an insured health plan which  
 25                           is experience-rated,

1 but any such plan may cover only experience-  
2 rated individuals.

3 “(2) SUBSIDIZED COVERAGE.—Individuals shall  
4 be entitled to such premium assistance as is pro-  
5 vided under the program described in part B of title  
6 XIX.

7 “(c) ACCESS THROUGH HEALTH PLAN SPONSORS.—  
8 Subject to the requirements of part II of subtitle B—

9 “(1) a State program shall require each health  
10 plan sponsor to make available to each community-  
11 rated individual the opportunity to enroll, directly or  
12 through a purchasing cooperative, in a certified  
13 health plan which provides the FedMed benefits  
14 package established under section 21115(b); and

15 “(2) each health plan sponsor may offer any  
16 other certified health plan which provides any other  
17 health benefits package, including a supplemental  
18 benefit package to the FedMed benefits package, but  
19 may not require an individual or group to purchase  
20 supplemental coverage or link the pricing of the  
21 FedMed benefits package to the purchase of a sup-  
22 plemental benefits package.

23 **“SEC. 21003. GENERAL DEFINITIONS RELATING TO HEALTH**  
24 **PLANS.**

25 “(a) HEALTH PLAN.—For purposes of this title—

1           “(1) IN GENERAL.—The term ‘health plan’  
2       means any plan or arrangement which provides, or  
3       pays the cost of, health benefits. Such term does not  
4       include the following, or any combination thereof:

5           “(A) Coverage only for accidental death,  
6       dismemberment, dental, or vision.

7           “(B) Coverage providing wages or pay-  
8       ments in lieu of wages for any period during  
9       which the employee is absent from work on ac-  
10      count of sickness or injury.

11          “(C) A medicare supplemental policy (as  
12      defined in section 1882(g)(1)).

13          “(D) Coverage issued as a supplement to  
14      liability insurance.

15          “(E) Worker’s compensation or similar in-  
16      surance.

17          “(F) Automobile medical-payment insur-  
18      ance.

19          “(G) A long-term care insurance policy, in-  
20      cluding a nursing home fixed indemnity policy  
21      (unless the Secretary determines that such a  
22      policy provides sufficiently comprehensive cov-  
23      erage of a benefit so that it should be treated  
24      as a health plan).

25          “(H) An equivalent health care program.

1           “(I) Any plan or arrangement not de-  
2           scribed in any preceding subparagraph which  
3           provides for benefit payments, on a periodic  
4           basis, for a specified disease or illness or period  
5           of hospitalization without regard to the costs in-  
6           curred or services rendered during the period to  
7           which the payments relate.

8           “(J) Such other plan or arrangement as  
9           the Secretary determines is not a health plan.

10          “(2) INSURED HEALTH PLAN.—

11               “(A) IN GENERAL.—The term ‘insured  
12               health plan’ means any health plan which is a  
13               hospital or medical service policy or certificate,  
14               hospital or medical service plan contract, or  
15               health maintenance organization group contract  
16               offered by an insurer.

17               “(B) INSURER.—The term ‘insurer’  
18               means—

19                       “(i) a licensed insurance company,

20                       “(ii) a prepaid hospital or medical  
21                       service plan,

22                       “(iii) a health maintenance organiza-  
23                       tion, or

24                       “(iv) any other similar entity,



1           which is engaged in the business of providing a  
 2           plan of health insurance or health benefits or  
 3           services.

4           “(3) SELF-INSURED HEALTH PLAN.—The term  
 5           ‘self-insured health plan’ means an employee welfare  
 6           benefit plan, church plan, government plan, or other  
 7           arrangement which—

8                   “(A) provides health benefits funded in a  
 9                   manner other than through the purchase of one  
 10                  or more insured health plans, but

11                   “(B) does not include any coverage or in-  
 12                  surance described in subparagraphs (A)  
 13                  through (J) of paragraph (1).

14           “(b) CERTIFIED HEALTH PLAN.—For purposes of  
 15           this title, the term ‘certified health plan’ means a health  
 16           plan which is certified by the appropriate certifying au-  
 17           thority as meeting the applicable requirements of this title.

18           “(c) TERMS AND RULES RELATING TO COMMUNITY  
 19           AND EXPERIENCE RATING.—For purposes of this title—

20                   “(1) COMMUNITY-RATED HEALTH PLAN.—The  
 21                  term ‘community-rated health plan’ means a health  
 22                  plan which meets the requirements of section 21114.

23                   “(2) COMMUNITY-RATED INDIVIDUAL.—The  
 24                  term ‘community-rated individual’ means an individ-  
 25                  ual—

1           “(A) who is not an experience-rated indi-  
2           vidual, or

3           “(B) who is an experience-rated individual  
4           (determined without regard to this subpara-  
5           graph) and whose employer does not provide an  
6           employer-subsidized certified health plan.

7           Such term includes the spouse and dependents of  
8           such individual.

9           “(3) EXPERIENCE-RATED INDIVIDUAL.—The  
10          term ‘experience-rated individual’ means an individ-  
11          ual who is an employee of an experience-rated em-  
12          ployer. Such term includes the spouse and depend-  
13          ents of such individual.

14          “(4) EXPERIENCE-RATED EMPLOYER.—

15                 “(A) IN GENERAL.—The term ‘experience-  
16                 rated employer’ means—

17                         “(i) in the case of a self-insured  
18                         health plan, any employer, and

19                         “(ii) in the case of an insured health  
20                         plan, with respect to any calendar year,  
21                         any employer if, on each of 20 days during  
22                         the preceding calendar year (each day  
23                         being in a different week), such employer  
24                         (or any predecessor) employed more than  
25                         50 employees for some portion of the day.

1           “(B) CERTAIN OTHER PLANS.—Such term  
 2           shall include multiemployer plans, church asso-  
 3           ciation plans, and rural electric cooperative or  
 4           rural telephone cooperative association plans.

5           “(5) SPECIAL RULE FOR SPOUSES AND DE-  
 6           PENDENTS.—If any individual is offered coverage  
 7           under a health plan as the spouse or a dependent of  
 8           a primary enrollee of such plan, such individual shall  
 9           have the status of such enrollee unless such individ-  
 10          ual is eligible to elect other coverage and so elects.

## 11       **“PART II—CERTIFICATION AND CONSUMER**

### 12                               **VALUE**

#### 13       **“SEC. 21011. CERTIFICATION OF HEALTH PLANS.**

14           “(a) IN GENERAL.—Each State program shall pro-  
 15          vide for the certification of health plans as certified health  
 16          plans in accordance with the insurance reform standards  
 17          and the delivery system guidelines established by the Sec-  
 18          retary under subtitle B.

19           “(b) USE OF PRIVATE ENTITIES.—

20           “(1) EXPERTS.—A State shall consult with ex-  
 21          perts in designing and implementing a State certifi-  
 22          cation program under this section.

23           “(2) ACCREDITATION.—A State program may  
 24          provide for the use of private accreditation entities

1 in carrying out all or part of the duties under sub-  
2 section (a).

3 “(c) COORDINATION OF ACTIVITIES.—In designing  
4 and implementing the State certification program under  
5 this section, a State shall coordinate activities by State  
6 public health offices with activities of the insurance com-  
7 missioner of the State, and with other relevant State agen-  
8 cies, with respect to the duties and responsibilities of each  
9 such entity.

10 “(d) CERTIFICATION FEES.—A State program may  
11 impose appropriate certification fees on health plans seek-  
12 ing certification.

13 “(e) CERTIFICATION ENFORCEMENT.—A State pro-  
14 gram shall provide for the monitoring and enforcement of  
15 the certification of health plans.

16 **“SEC. 21012. CONSUMER VALUE PROGRAM.**

17 “(a) ESTABLISHMENT OF PROGRAM.—Each State, in  
18 accordance with minimum guidelines established by the  
19 Secretary under section 21103, shall establish and operate  
20 a consumer value program to provide consumers in the  
21 State with comparative value information on the perform-  
22 ance of all health plans in each community rating area  
23 in the State. State consumer value programs under this  
24 section may exceed the guidelines established by the Sec-  
25 retary.

1       “(b) USE OF PRIVATE ORGANIZATIONS.—A State  
 2 may operate the consumer value program through a con-  
 3 tract with a private organization selected by the State.

4       “(c) ELIGIBILITY FOR GRANTS.—Each State with a  
 5 consumer value program shall be eligible for grants under  
 6 section 21103(b). To be eligible for such a grant, a State  
 7 shall prepare and submit to the Secretary an application  
 8 at such time, in such manner, and containing such infor-  
 9 mation as the Secretary may require.

10       “(d) ADDITIONAL REQUIREMENTS.—Each State pro-  
 11 gram shall meet the requirements specified under subtitles  
 12 B and C of title XI with respect to certified health plans.

13       **“SEC. 21013. ESTABLISHMENT OF COMMUNITY RATING**  
 14                               **AREAS.**

15       “(a) ESTABLISHMENT.—Each participating State  
 16 under the State program shall, by not later than January  
 17 1, 1998, provide for the inclusion of all areas of the State  
 18 into 1 or more community rating areas. The program may  
 19 revise the boundaries of such areas from time to time con-  
 20 sistent with this section.

21       “(b) MULTIPLE AREAS.—With respect to a commu-  
 22 nity rating area—

23               “(1) no metropolitan statistical area or primary  
 24       metropolitan statistical area in a State may be di-

1 vided into more than 1 community rating area in  
2 such State;

3 “(2) the number of individuals residing within  
4 a community rating area may not be less than  
5 250,000; and

6 “(3) no area incorporated into a community  
7 rating area may be incorporated into another com-  
8 munity rating area.

9 “(c) BOUNDARIES.—In establishing boundaries for  
10 community rating areas, a participating State may not  
11 discriminate on the basis of, or otherwise take into ac-  
12 count, disability, health status, or perceived need for  
13 health services of a particular population. Such restric-  
14 tions shall not prohibit participating States from establish-  
15 ing such boundaries to ensure that underserved and vul-  
16 nerable populations are better served.

17 “(d) INTERSTATE AREAS.—Two or more contiguous  
18 participating States may provide for the establishment of  
19 a community rating area that includes adjoining areas of  
20 the States so long as all areas of any metropolitan statis-  
21 tical area or primary metropolitan statistical area within  
22 such States are within the same community rating area.

23 **“SEC. 21014. RISK ADJUSTMENT PROGRAMS.**

24 “Each participating State under the State program  
25 shall provide a risk adjustment program meeting the

1 standards developed by the Secretary under section  
2 21104.

3 **“SEC. 21015. SPECIFICATION OF INITIAL GENERAL ENROLL-**  
4 **MENT PERIOD.**

5 “Upon the date of the commencement of the State  
6 program, the participating State shall specify for the State  
7 (or for each community rating area) an initial period, of  
8 not less than 90 days, during which individuals in the  
9 State (or area) may enroll in certified health plans.

10 **“PART III—TREATMENT OF CERTAIN STATE**  
11 **LAWS**

12 **“SEC. 21021. PREEMPTION OF CERTAIN STATE LAW RE-**  
13 **STRICTIONS ON HEALTH PLANS.**

14 “Effective as of January 1, 1996—

15 “(1) a State may not prohibit or limit a health  
16 plan from including incentives for enrollees to use  
17 the services of participating providers;

18 “(2) a State may not prohibit or limit a health  
19 plan from requiring enrollees to obtain care from  
20 participating providers;

21 “(3) a State may not prohibit or limit a health  
22 plan from requiring enrollees to obtain referrals for  
23 specialty treatment;

1           “(4) a State may not prohibit or limit the es-  
2           tablishment of different payment rates for partici-  
3           pating and non-participating providers;

4           “(5) a State may not prohibit or limit a health  
5           plan from limiting the number and types of partici-  
6           pating providers;

7           “(6) a State may not prohibit or limit a health  
8           plan from using single source suppliers for pharmacy  
9           services, medical equipment, and other supplies and  
10          services; and

11          “(7) a State may not prohibit or limit the cor-  
12          porate practice of medicine.

13   **“SEC. 21022. PREEMPTION FROM STATE BENEFIT MAN-**  
14                   **DATES.**

15          “Effective as of January 1, 1996, no State shall es-  
16          tablish or enforce any law or regulation that requires any  
17          certified health plan to cover any specific item or service.

18   **“SEC. 21023. PREEMPTION OF STATE LAW REGULATING**  
19                   **UTILIZATION MANAGEMENT AND REVIEW.**

20          “Effective as of January 1, 1996, a State may not  
21          regulate utilization management and review programs of  
22          any health plan to the extent not provided by this title.



1 **“SEC. 21024. STATE LAWS REGARDING END OF LIFE TREAT-**  
 2 **MENT.**

3 “Nothing in this title shall be construed to invalidate  
 4 any State law that has the effect of preventing involuntary  
 5 denial of lifesaving medical treatment when such denial  
 6 would cause the involuntary death of the patient pending  
 7 transfer of the patient to a health care provider willing  
 8 to provide such treatment.

9 **“PART IV—DEFINITIONS AND RULES**

10 **“SEC. 21100. DEFINITIONS AND RULES OF GENERAL APPLI-**  
 11 **CATION.**

12 “Except as otherwise specifically provided, in this  
 13 title the following definitions and rules apply:

14 “(1) APPROPRIATE CERTIFYING AUTHORITY.—

15 The term ‘appropriate certifying authority’ means—

16 “(A) except as provided in subparagraph  
 17 (B), in the case of an insured health plan, the  
 18 State commissioner or superintendent of insur-  
 19 ance or other State authority in the participat-  
 20 ing State; or

21 “(B) in the case of a self-insured health  
 22 plan, the Secretary of Labor.

23 “(2) CHURCH ASSOCIATION PLAN.—The term  
 24 ‘church association plan’ means a church plan (as  
 25 defined in section 414(e) of the Internal Revenue  
 26 Code of 1986).

1           “(3) DELIVERY SYSTEM.—The term ‘delivery  
2           system’ with respect to a health plan includes a fee-  
3           for-service, use of preferred providers, staff or group  
4           model health maintenance organizations, and such  
5           other arrangements as the Secretary may recognize.

6           “(4) DEPENDENT.—The term ‘dependent’  
7           means, with respect to any individual, any person—

8                   “(A) who is a child or stepchild of the indi-  
9           vidual; and

10                   “(B) who is—

11                           “(i) under 22 years of age (under 25  
12                           years of age in the case of a fulltime stu-  
13                           dent) and unmarried, or

14                           “(ii) permanently and totally disabled  
15                           (within the meaning of section  
16                           151(c)(5)(C) of such Code).

17           “(5) EMPLOYER, EMPLOYEE, AND EMPLOY-  
18           MENT DEFINED.—

19                   “(A) IN GENERAL.—Except as otherwise  
20           provided in this subtitle—

21                           “(i) the term ‘employment’ has the  
22                           meaning given such term under section  
23                           3121 of the Internal Revenue Code of  
24                           1986,

1           “(ii) the term ‘employee’ has the  
2 meaning given such term under section  
3 3121 of such Code, subject to the provi-  
4 sions of chapter 25 of such Code, and

5           “(iii) the term ‘employer’ has the  
6 same meaning as the term “employer” as  
7 used in such section 3121.

8           “(B) EXCEPTIONS.—For purposes of sub-  
9 paragraph (A)—

10           “(i) EMPLOYMENT.—

11           “(I) EMPLOYMENT INCLUDED.—  
12 Paragraphs (1), (2), (5), (7) (other  
13 than clauses (i) through (iv) of sub-  
14 paragraph (C) and clauses (i) through  
15 (v) of subparagraph (F)), (8), (9),  
16 (10), (11), (13), (15), (18), and (19)  
17 of section 3121(b) of the Internal  
18 Revenue Code of 1986 shall not apply.

19           “(II) EXCLUSION OF SEASONAL  
20 OR TEMPORARY.—Employment shall  
21 not include seasonal or temporary  
22 services performed for an employer for  
23 less than 6 months in a calendar year.

24           “(ii) EMPLOYEES.—

1           “(I) TREATMENT OF SELF-EM-  
2           PLOYED.—The term ‘employee’ in-  
3           cludes a self-employed individual.

4           “(II) EXCLUSION OF CERTAIN  
5           FOREIGN EMPLOYMENT.—The term  
6           ‘employee’ does not include an individ-  
7           ual with respect to service, if the indi-  
8           vidual is not a citizen or resident of  
9           the United States and the service is  
10          performed outside the United States.

11          “(C) AGGREGATION RULES FOR EMPLOY-  
12          ERS.—For purposes of this title—

13               “(i) all employers treated as a single  
14               employer under subsection (a) or (b) of  
15               section 52 of the Internal Revenue Code of  
16               1986 shall be treated as a single employer,  
17               and

18               “(ii) under regulations of the Sec-  
19               retary of the Treasury, all employees of or-  
20               ganizations which are under common con-  
21               trol with one or more organizations which  
22               are exempt from income tax under subtitle  
23               A of the Internal Revenue Code of 1986  
24               shall be treated as employed by a single  
25               employer.

1           The regulations prescribed under clause (ii)  
2           shall be based on principles similar to the prin-  
3           ciples which apply to taxable organizations  
4           under clause (i).

5           “(6) EQUIVALENT HEALTH CARE PROGRAM.—

6           The term ‘equivalent health care program’ means—

7                   “(A) part A or part B of the medicare pro-  
8                   gram under title XVIII of the Social Security  
9                   Act,

10                   “(B) the medicaid program under title  
11                   XIX of the Social Security Act,

12                   “(C) the health care program for active  
13                   military personnel under title 10, United States  
14                   Code,

15                   “(D) the veterans health care program  
16                   under chapter 17 of title 38, United States  
17                   Code,

18                   “(E) the Civilian Health and Medical Pro-  
19                   gram of the Uniformed Services (CHAMPUS),  
20                   as defined in section 1073(4) of title 10, United  
21                   States Code, and

22                   “(F) the Indian health service program  
23                   under the Indian Health Care Improvement Act  
24                   (25 U.S.C. 1601 et seq.).

1           “(7) FAMILY.—The term ‘family’ includes an  
2 individual, the individual’s spouse, and the individ-  
3 ual’s dependents (if any), as defined in paragraph  
4 (4).

5           “(8) HEALTH PLAN SPONSOR.—The term  
6 ‘health plan sponsor’ means, with respect to—

7               “(A) an insured health plan, the insurer,  
8 and

9               “(B) a self-insured health plan, the experi-  
10 ence-rated employer sponsor.

11           “(9) MULTIEMPLOYER PLAN.—The term ‘multi-  
12 employer plan’ has the meaning given such term in  
13 section 3(37) of the Employee Retirement Income  
14 Security Act of 1974, and includes any plan that is  
15 treated as such a plan under title I of such Act.

16           “(10) NAIC.—The term ‘NAIC’ means the Na-  
17 tional Association of Insurance Commissioners.

18           “(11) PARTICIPATING STATE.—The term ‘par-  
19 ticipating State’ means a State establishing a State  
20 program under this title.

21           “(12) PURCHASING COOPERATIVE.—The term  
22 ‘purchasing cooperative’ means a health insurance  
23 purchasing cooperative described in section 21201.

24           “(13) RURAL ELECTRIC COOPERATIVE.—The  
25 term ‘rural electric cooperative’ has the meaning

1 given such term in section 3(40)(A)(iv) of the Em-  
 2 ployee Retirement Income Security Act of 1974.

3 “(14) RURAL TELEPHONE COOPERATIVE ASSO-  
 4 CIATIONS.—The term ‘rural telephone cooperative  
 5 association’ has the meaning given such term in sec-  
 6 tion 3(40)(A)(v) of the Employee Retirement Income  
 7 Security Act of 1974.

8 “(15) SECRETARY.—The term ‘Secretary’  
 9 means the Secretary of Health and Human Services  
 10 or the Secretary’s delegate.

11 “(16) STATE.—The term ‘State’ means each of  
 12 the several States, the District of Columbia, the  
 13 Commonwealth of Puerto Rico, the United States  
 14 Virgin Islands, Guam, American Samoa, and the  
 15 Commonwealth of the Northern Mariana Islands.

## 16 **“Subtitle B—Standards for Reform**

### 17 **“PART I—ESTABLISHMENT AND APPLICATION OF** 18 **STANDARDS AND GUIDELINES**

#### 19 **“SEC. 21101. INSURANCE REFORM STANDARDS.**

20 “Except as provided in section 21105, the Secretary,  
 21 in consultation with the NAIC, shall develop and publish  
 22 specific standards and evaluation criteria to implement the  
 23 insurance reform standards specified in part II by not  
 24 later than 9 months after the date of the enactment of  
 25 this title.

1 **“SEC. 21102. DELIVERY SYSTEM GUIDELINES.**

2 “(a) ESTABLISHMENT.—Except as provided in sec-  
3 tion 21105, not later than 9 months after the date of en-  
4 actment of this title, the Secretary, in consultation with  
5 the NAIC and other organizations with expertise in the  
6 areas of quality assurance (including the Joint Commis-  
7 sion on Accreditation of Health Care Organizations, the  
8 National Committee for Quality Assurance, and peer re-  
9 view organizations), shall establish minimum guidelines  
10 specified in part III for the certification of health plan  
11 delivery systems and the enforcement of such guidelines.

12 “(b) MINIMUM GUIDELINES.—Each participating  
13 State through the State program may exceed the guide-  
14 lines established by the Secretary under this section.

15 **“SEC. 21103. CONSUMER VALUE PROGRAM.**

16 “(a) DEVELOPMENT OF GUIDELINES.—The Sec-  
17 retary shall develop and distribute to participating States  
18 model minimum guidelines for the establishment of State  
19 consumer value programs under section 21012. Such  
20 guidelines shall include a description of a consumer report  
21 card that is designed to standardize consumer information  
22 among all States concerning certified health plans.

23 “(b) GRANT PROGRAM.—The Secretary may award  
24 demonstration grants to States that establish consumer  
25 value programs, with priority given by the Secretary to



1 States that exceed the minimum guidelines established by  
2 the Secretary under this section.

3 “(c) AUTHORIZATION OF APPROPRIATIONS.—There  
4 are authorized to be appropriated such sums as are nec-  
5 essary to carry out the purposes of this section.

6 **“SEC. 21104. RISK ADJUSTMENT PROGRAMS.**

7 “Except as provided in section 21105, the Secretary  
8 shall develop standards for participating States to provide  
9 risk adjustment programs for participation by community-  
10 rated insured health plans and reinsurers of self-insured  
11 health plans sponsored by employers which are not experi-  
12 ence-rated employers as described in section 21116(b).

13 **“SEC. 21105. STANDARDS AND GUIDELINES BY SECRETARY**  
14 **OF LABOR.**

15 “The Secretary of Labor shall develop for self-insured  
16 health plans appropriate insurance reform standards and  
17 minimum delivery system guidelines similar to such stand-  
18 ards and guidelines described in sections 21101 and  
19 21102.

20 **“SEC. 21106. GENERAL RULES.**

21 “(a) CONSTRUCTION.—Whenever in this subtitle a  
22 requirement or standard is imposed on a health plan, the  
23 requirement or standard is deemed to have been imposed  
24 on the insurer or sponsor of the plan in relation to that  
25 plan.

1       “(b) USE OF INTERIM, FINAL REGULATIONS.—In  
 2 order to permit the timely implementation of the provi-  
 3 sions of this title, the Secretary and the Secretary of  
 4 Labor are each authorized to issue regulations under this  
 5 title on an interim basis that become final on the date  
 6 of publication, subject to change based on subsequent pub-  
 7 lic comment.

8       “(c) REFERENCE TO REFORM STANDARDS.—For  
 9 purposes of this title, the term ‘reform standards’ means  
 10 the standards developed under this subtitle and applicable  
 11 under part II.

12       **“PART II—INSURANCE REFORM STANDARDS**

13               **APPLICABLE TO HEALTH PLANS**

14       **“SEC. 21111. GUARANTEED ISSUE AND RENEWAL.**

15       “(a) ISSUE.—

16               “(1) IN GENERAL.—Except as otherwise pro-  
 17 vided in this section, a health plan sponsor—

18                       “(A) offering a community-rated health  
 19 plan shall offer such plan to any community-  
 20 rated individual applying for coverage; and

21                       “(B) offering an experience-rated health  
 22 plan or a self-insured health plan shall offer  
 23 such plan to any experience-rated individual eli-  
 24 gible for coverage under the plan through the  
 25 individual’s experience-rated employer.

1 “(2) AVAILABILITY.—

2 “(A) IN GENERAL.—A community-rated  
3 health plan shall be made available throughout  
4 the entire community rating area in which such  
5 plan is offered, including through any purchas-  
6 ing cooperative choosing to offer such plan.

7 “(B) GEOGRAPHIC LIMITATIONS.—A com-  
8 munity-rated health plan may deny coverage  
9 under the plan to a community-rated individual  
10 who resides outside the community rating area  
11 in which such plan is offered, but only if such  
12 denial is applied uniformly, without regard to  
13 health status or insurability of individuals.

14 “(C) APPLICABILITY TO NETWORK  
15 PLANS.—Subparagraphs (A) and (B) shall each  
16 be applied to a community-rated health plan  
17 using a staff or group model health mainte-  
18 nance organization or other network delivery  
19 system by substituting ‘service area determined  
20 by the appropriate certifying authority’ for  
21 ‘community rating area’.

22 “(3) APPLICATION OF CAPACITY LIMITS.—

23 “(A) IN GENERAL.—Subject to subpara-  
24 graph (B), an insured health plan may apply to

1 the appropriate certifying authority to cease en-  
2 rolling individuals under the plan if—

3 “(i) the plan ceases to enroll any new  
4 individuals; and

5 “(ii) the plan can demonstrate to the  
6 applicable certifying authority that its fi-  
7 nancial or provider capacity to serve pre-  
8 viously covered groups or individuals (and  
9 additional individuals who will be expected  
10 to enroll because of affiliation with such  
11 previously covered groups or individuals)  
12 will be impaired if it is required to enroll  
13 other individuals.

14 “(B) FIRST-COME-FIRST-SERVED.—An in-  
15 sured health plan is only eligible to exercise the  
16 limitations provided for in subparagraph (A) if  
17 such plan provides for enrollment of individuals  
18 on a first-come-first-served basis (except in the  
19 case of additional individuals described in sub-  
20 paragraph (A)(ii)).

21 “(b) RENEWAL.—

22 “(1) IN GENERAL.—Except as provided in para-  
23 graphs (2) and (3), a health plan that is issued to  
24 an individual shall be renewed at the option of the  
25 individual.

1           “(2) GROUNDS FOR REFUSAL TO RENEW.—A  
2 health plan sponsor may refuse to renew, or may  
3 terminate, a health plan under this title only for—

4                   “(A) nonpayment of premiums;

5                   “(B) fraud on the part of the individual; or

6                   “(C) misrepresentation of material facts on  
7 the part of the individual relating to an applica-  
8 tion for coverage or claim for benefits.

9           “(3) EXIT FROM MARKET.—

10                   “(A) IN GENERAL.—An insurer shall  
11 renew an insured health plan through a particu-  
12 lar type of delivery system (as defined in sec-  
13 tion 21100) with respect to a community-rated  
14 employer or community-rated individual, unless  
15 such insurer—

16                   “(i) elects not to renew all of its insured  
17 health plans using such delivery system issued  
18 to all such employers and individuals in a State;  
19 and

20                   “(ii) provides notice to the appropriate cer-  
21 tifying authority and to each such employer and  
22 individual covered under the plan of such termi-  
23 nation at least 180 days before the date of expi-  
24 ration of the plan.

1           “(B) PROHIBITION ON MARKET RE-  
 2 ENTRY.—In the case of such a termination,  
 3 such insurer may not provide for the issuance  
 4 of any insured health plan using such a delivery  
 5 system to a community-rated employer or com-  
 6 munity-rated individual in such State during  
 7 the 5-year period beginning on the date of the  
 8 termination of the last plan not so renewed.

9           “(c) CERTAIN EXCLUDED PLANS.—The provisions of  
 10 this section, other than subsections (b) and (e)(2)(B),  
 11 shall not apply to any religious fraternal benefit society  
 12 in existence as of September 1993, which bears the risk  
 13 of providing insurance to its members, and which is an  
 14 organization described in section 501(c)(8) of the Internal  
 15 Revenue Code of 1986 which is exempt from taxation  
 16 under section 501(a) of such Code.

17 **“SEC. 21112. ENROLLMENT.**

18           “(a) ENROLLMENT PROCESS.—A health plan shall  
 19 establish an enrollment process which consists of—

20                   “(A) a general annual enrollment period of  
 21 at least 30 days; and

22                   “(B) special enrollment periods for  
 23 changes in enrollment,

24 as specified by the reform standards, which shall in-  
 25 clude the circumstances under which such special en-

1       rollment periods are required and the duration of  
2       such periods.

3       “(b) COMMENCEMENT OF COVERAGE.—

4               “(1) WAITING PERIODS.—An insurer or an em-  
5       ployer may impose a waiting period of not more  
6       than 30 days for coverage for a reasonable time nec-  
7       essary to process an enrollment.

8               “(2) NEWBORNS.—In the event of the birth or  
9       adoption of a child of an enrollee, coverage of such  
10      child under such enrollee’s health plan (regardless of  
11      the class of enrollment) shall begin on the date of  
12      such birth or adoption and shall continue, in the ab-  
13      sence of any enrollment of such child during a spe-  
14      cial enrollment period provided under subsection  
15      (a)(1)(C), for at least 45 days.

16   **“SEC. 21113. NONDISCRIMINATION BASED ON HEALTH STA-**  
17               **TUS.**

18       “(a) IN GENERAL.—Except as provided under sub-  
19      section (b), a health plan may not—

20               “(1) deny, limit, or condition the coverage  
21      under (or benefits of) the plan; and

22               “(2) in the case of an experience-rated health  
23      plan, vary the premium,

24      based on the health status, medical condition, claims expe-  
25      rience, receipt of health care, medical history, anticipated

1 need for health care expenses, disability, or lack of evi-  
2 dence of insurability, of an individual.

3 “(b) TREATMENT OF PREEXISTING CONDITION EX-  
4 CLUSIONS FOR ALL SERVICES.—

5 “(1) IN GENERAL.—Subject to paragraph (4), a  
6 health plan may impose a limitation or exclusion of  
7 benefits relating to treatment of a condition based  
8 on the fact that the condition preexisted the effective  
9 date of the plan with respect to an individual enroll-  
10 ing as a member of a group only if—

11 “(A) the condition was diagnosed or treat-  
12 ed during the 3-month period ending on the day  
13 before the date of enrollment under the plan;

14 “(B) the limitation or exclusion extends for  
15 a period not more than 6 months after the date  
16 of enrollment under the plan;

17 “(C) the limitation or exclusion does not  
18 apply to an individual who, as of the date of  
19 birth, was covered under the plan; or

20 “(D) the limitation or exclusion does not  
21 apply to pregnancy.

22 “(2) CREDITING OF PREVIOUS COVERAGE.—A  
23 health plan shall provide that if an individual under  
24 such plan is in a period of continuous coverage as  
25 of the date of enrollment under such plan, any pe-



1       riod of exclusion of coverage with respect to a pre-  
2       existing condition shall be reduced by 1 month for  
3       each month in the period of continuous coverage.

4           “(3) DEFINITIONS.—As used in this subsection:

5               “(A) PERIOD OF CONTINUOUS COV-  
6       ERAGE.—The term ‘period of continuous cov-  
7       erage’ means the period beginning on the date  
8       an individual is enrolled under a certified health  
9       plan or an equivalent health care program and  
10      ends on the date the individual is not so en-  
11      rolled for a continuous period of more than 3  
12      months.

13           “(B) PREEXISTING CONDITION.—The term  
14      ‘preexisting condition’ means, with respect to  
15      coverage under a health plan, a condition which  
16      was diagnosed, or which was treated, within the  
17      3-month period ending on the day before the  
18      date of enrollment (without regard to any wait-  
19      ing period).

20           “(4) SPECIAL RULES FOR INDIVIDUALS.—In  
21      the case of an individual who is not enrolling as a  
22      member of a group in a health plan—

23               “(A) any reference to 3 months in para-  
24      graph (1)(A) is deemed a reference to 6  
25      months,

1           “(B) any reference to 6 months in para-  
 2           graphs (1)(B) and (2) is deemed a reference to  
 3           12 months, and

4           “(C) any reference to 3-month period in  
 5           paragraph (3)(B) is deemed a reference to 6-  
 6           month period.

7           “(5) PROHIBITION ON PREEXISTING CONDITION  
 8           EXCLUSION DURING AMNESTY PERIOD.—

9           “(A) IN GENERAL.—This subsection shall  
 10          not apply during an initial enrollment period  
 11          described in section 21015.

12          “(B) CAPACITY LIMITATION.—The partici-  
 13          pating State may establish a limit on the num-  
 14          ber of new enrollees a health plan must accept  
 15          during the period described in subparagraph  
 16          (A) based on the plan’s share of the applicable  
 17          community-rated or experience-rated popu-  
 18          lation.

19   **“SEC. 21114. RATING LIMITATIONS FOR COMMUNITY-RATED**  
 20       **MARKET.**

21          “(a) STANDARD PREMIUMS WITH RESPECT TO COM-  
 22          MUNITY-RATED INDIVIDUALS.—Each community-rated  
 23          health plan shall establish within each community rating  
 24          area in which the plan is to be offered a standard premium  
 25          for individual enrollment for each benefits package of the

1 plan, including the FedMed benefits package established  
2 under section 21115(b).

3 “(b) UNIFORM PREMIUMS WITHIN COMMUNITY RAT-  
4 ING AREAS.—

5 “(1) IN GENERAL.—Subject to paragraphs (2),  
6 (3), and (4), the standard premium for each package  
7 described in subsection (a) for all community-rated  
8 individuals within a community rating area shall be  
9 the same and shall not include the costs of premium  
10 processing, enrollment, and marketing that would  
11 vary depending on whether the method of enrollment  
12 is through a purchasing cooperative, or directly  
13 through a health plan sponsor, an employer, or a  
14 broker.

15 “(2) APPLICATION TO ENROLLEES.—

16 “(A) IN GENERAL.—The premium charged  
17 for coverage in a community-rated health plan  
18 shall be the product of—

19 “(i) the standard premium (estab-  
20 lished under paragraph (1));

21 “(ii) in the case of enrollment other  
22 than individual enrollment, the family ad-  
23 justment factor specified under subpara-  
24 graph (B); and

1 “(iii) the age adjustment factor (spec-  
2 ified under subparagraph (C)).

3 “(B) FAMILY ADJUSTMENT FACTOR.—The  
4 reform standards shall specify family adjust-  
5 ment factors that reflect the relative actuarial  
6 costs of benefit packages based on family class-  
7 es of enrollment (as compared with such costs  
8 for individual enrollment).

9 “(C) AGE ADJUSTMENT FACTOR.—The re-  
10 form standards shall specify uniform age cat-  
11 egories for age adjustment factors that reflect  
12 the relative actuarial costs of benefit packages  
13 among enrollees. For individuals who have at-  
14 tained age 18 but not age 65, the highest age  
15 adjustment factor may not exceed the lowest  
16 age adjustment factor by—

17 “(i) 4 times for the first 3 years be-  
18 ginning with the first year of certification  
19 by the appropriate certifying authority,  
20 and

21 (ii) 3 times for years thereafter.

22 “(3) ADMINISTRATIVE CHARGES.—

23 “(A) IN GENERAL.—In accordance with  
24 the reform standards, a community-rated health  
25 plan may add a separately-stated administrative

1 charge not to exceed 15 percent of the plan's  
2 premium which is based on identifiable dif-  
3 ferences in marketing and other legitimate ad-  
4 ministrative costs which vary by size of the en-  
5 rolling group and method of enrollment, includ-  
6 ing enrollment directly through a health plan,  
7 an employer, or a broker (as defined in such  
8 standards).

9 “(B) APPLICATION.—The administrative  
10 charge for any plan described in subparagraph  
11 (A) shall be applied uniformly with respect to  
12 group size and method of enrollment.

13 “(4) DISCOUNTS.—In accordance with the re-  
14 form standards, an insurer may allow premium dis-  
15 counts based on health promoting activities.

16 **“SEC. 21115. BENEFITS OFFERED.**

17 “(a) OFFERING OF PACKAGES INCLUDING  
18 FEDMED.—Subject to the requirements of section  
19 21002(c), a health plan may offer, in addition to a  
20 FedMed benefits package, other benefits packages in a  
21 community rating area, if the rates for all such packages  
22 (including the FedMed) are based on the plan's total en-  
23 rollment in the community-rated population in such area  
24 and the rating variations do not exceed the difference in

1 the actuarial value of the specific benefit variations for  
2 such population.

3 “(b) FEDMED BENEFITS PACKAGE DESCRIBED.—

4 “(1) IN GENERAL.—

5 “(A) PACKAGE DESCRIBED.—A FedMed  
6 benefits package described in this subsection is  
7 a benefits package that covers all of the items  
8 and services under the categories of health care  
9 items and services specified by the Secretary  
10 under paragraph (2) when medically necessary  
11 or appropriate (as determined in accordance  
12 with paragraph (3)) and provides for a cost-  
13 sharing schedule specified by the Secretary  
14 under paragraph (4).

15 “(B) ACTUARIAL VALUE.—

16 “(i) INITIAL PACKAGE.—For 1997,  
17 the FedMed benefits package established  
18 by the Secretary under this subsection that  
19 has the lowest actuarial value of all the  
20 FedMed benefits packages established by  
21 the Secretary under this subsection, shall  
22 have an actuarial value that equals the ac-  
23 tual value of the benefits package pro-  
24 vided under the health benefits plan of-  
25 fered under chapter 89 of title 5, United

1 States Code, during 1994 with the highest  
2 enrollment, adjusted for a national popu-  
3 lation under 65 years of age (as deter-  
4 mined by the Secretary).

5 “(ii) SUCCEEDING YEARS.—For suc-  
6 ceeding years, the FedMed benefits pack-  
7 age established by the Secretary under this  
8 subsection that has the lowest actuarial  
9 value of all the FedMed benefits packages  
10 established by the Secretary under this  
11 subsection for the year, shall have an actu-  
12 arial value that equals the actuarial value  
13 of the FedMed benefits package that has  
14 the lowest actuarial value of all the  
15 FedMed benefits packages that existed in  
16 the preceding year.

17 “(iii) DETERMINING ACTUARIAL  
18 VALUE.—For purposes of clause (ii), the  
19 Secretary shall use the same actuarial as-  
20 sumptions in determining the actuarial  
21 value of the FedMed benefits packages for  
22 the current and preceding years.

23 “(2) CATEGORIES OF HEALTH CARE ITEMS AND  
24 SERVICES.—

1           “(A) IN GENERAL.—The categories of  
 2 health care items and services specified by the  
 3 Secretary under this paragraph shall include at  
 4 least the categories described in section 1302(1)  
 5 of the Public Health Service Act and section  
 6 8904(a) of title 5, United States Code. The  
 7 Secretary may add or delete categories of health  
 8 care items and services under this paragraph as  
 9 medical practice changes.

10           “(B) SPECIFYING ITEMS AND SERVICES.—

11           “(i) IN GENERAL.—The Secretary  
 12 shall specify the items and services under  
 13 the categories specified under subpara-  
 14 graph (A).

15           “(ii) PRIORITIES FOR THE SEC-  
 16 RETARY.—In specifying items and services  
 17 under this subparagraph the Secretary  
 18 shall take into account the following:

19           “(I) MENTAL HEALTH AND SUB-  
 20 STANCE ABUSE SERVICES.—With re-  
 21 spect to mental health and substance  
 22 abuse services, the Secretary shall  
 23 give priority to—

24           “(aa) parity for such serv-  
 25 ices with other medical services



1 with respect to cost-sharing and  
2 duration of treatment;

3 “(bb) management for such  
4 services that ensures access to  
5 medically appropriate treatment;  
6 and

7 “(cc) encouraging the use of  
8 outpatient treatments to the  
9 greatest extent feasible.

10 “(II) VULNERABLE POPU-  
11 LATIONS AND UNDERSERVED  
12 AREAS.—The Secretary shall give pri-  
13 ority to the needs of children and vul-  
14 nerable populations, including those  
15 populations in rural, frontier, and un-  
16 derserved areas.

17 “(III) PREVENTION.—The Sec-  
18 retary shall give priority to improving  
19 the health of individuals through pre-  
20 vention.

21 “(3) MEDICAL NECESSITY OR APPROPRIATE-  
22 NESS.—

23 “(A) DETERMINATIONS BY HEALTH  
24 PLANS.—

1           “(i) IN GENERAL.—The determination  
2           of medical necessity or appropriateness of  
3           specific treatments or procedures shall be  
4           made by individual health plans with ref-  
5           erence to criteria established under sub-  
6           paragraph (B).

7           “(ii) NEW PROCEDURES AND TECH-  
8           NOLOGIES.—Health plans may make cov-  
9           erage decisions regarding new procedures  
10          and technologies with reference to the cri-  
11          teria established by the Secretary under  
12          subparagraph (B).

13          “(B) CRITERIA ESTABLISHED.—The Sec-  
14          retary shall establish general criteria for deter-  
15          mining whether an item or service specified by  
16          the Secretary under paragraph (2)(B) is medi-  
17          cally necessary or appropriate.

18          “(4) COST-SHARING.—The Secretary shall es-  
19          tablish cost-sharing schedules to be provided by a  
20          FedMed benefits package. In establishing such cost-  
21          sharing schedules, the Secretary shall meet the fol-  
22          lowing requirements:

23               “(A) ANNUAL BASIS.—The Secretary shall  
24          review and update cost-sharing schedules as de-

1           terminated appropriate by the Secretary, but on  
2           at least an annual basis.

3           “(B) DELIVERY SYSTEMS.—

4                 “(i) IN GENERAL.—In establishing  
5           cost-sharing schedules for FedMed benefits  
6           packages, the Secretary shall ensure that  
7           the schedules permit a variety of delivery  
8           systems, including fee-for-service, preferred  
9           provider organizations, point of service,  
10          and health maintenance organizations.

11          “(ii) INITIAL COST-SHARING SCHED-  
12          ULES.—The cost-sharing schedules initially  
13          established by the Secretary shall meet the  
14          following requirements:

15                 “(I) MODERATE COST-SHAR-  
16           ING.—A moderate cost-sharing sched-  
17           ule shall be similar to the cost-sharing  
18           schedule under the health benefits  
19           plan offered under chapter 89 of title  
20           5, United States Code, with the high-  
21           est enrollment that uses a fee-for-serv-  
22           ice delivery system.

23                 “(II) LOW COST-SHARING.—A  
24           low cost-sharing schedule shall be  
25           similar to the cost-sharing schedule

1 under the health benefits plan offered  
2 under chapter 89 of title 5, United  
3 States Code, with the highest enroll-  
4 ment that provides a health mainte-  
5 nance organization.

6 “(III) INTERMEDIATE COST-  
7 SHARING.—An intermediate cost-shar-  
8 ing schedule for a preferred provider  
9 system, point of service system, or  
10 similar system, shall encourage use of  
11 providers in the network by providing  
12 for higher cost-sharing for out-of-net-  
13 work, non-emergency services.

14 “(C) COST-SHARING RULES.—Cost-sharing  
15 schedules established by the Secretary may in-  
16 clude copayments, coinsurance, deductibles, and  
17 out-of-pocket limits. The copayments, coinsur-  
18 ance, deductibles and out-of-pocket limits on  
19 cost-sharing for a year under the schedules  
20 shall be applied based upon expenses incurred  
21 for covered items and services furnished in the  
22 year.

23 “(c) LIFETIME LIMITATION PROHIBITED.—No  
24 health plan may impose a lifetime limitation on the provi-  
25 sion of benefits.

1   **“SEC. 21116. RISK ADJUSTMENT.**

2       “(a) IN GENERAL.—Each community-rated health  
3 plan shall participate in a risk adjustment program of the  
4 State described in section 21014.

5       “(b) MANDATORY STOP-LOSS INSURANCE.—Each  
6 employer which is not an experience-rated employer and  
7 which sponsors a self-insured health plan shall carry stop-  
8 loss insurance purchased from a reinsurer regulated by the  
9 participating State.

10   **“SEC. 21117. PROHIBITION OF DISCRIMINATION.**

11       “(a) IN GENERAL.—No State, health plan, or health  
12 plan sponsor may discriminate in participation, reimburse-  
13 ment, or indemnification against a health care provider  
14 who is acting within the scope of the provider’s license  
15 or certification under applicable State or Federal law sole-  
16 ly on the basis of such license or certification of such pro-  
17 vider.

18       “(b) NUMBER AND TYPE.—Nothing in this title  
19 shall—

20           “(1) prevent a health plan from matching the  
21 number and type of health care providers to the  
22 needs of the plan members; or

23           “(2) except as specifically provided in this title,  
24 establish any other measure designed to maintain  
25 quality or to control costs.

1           **“PART III—MINIMUM DELIVERY SYSTEM**  
2           **GUIDELINES APPLICABLE TO HEALTH PLANS**

3           **“SEC. 21121. MINIMUM DELIVERY SYSTEM GUIDELINES.**

4           “(a) IN GENERAL.—The minimum guidelines for the  
5 certification by a participating State of health plan deliv-  
6 ery systems specified under this part are as follows:

7                   “(1) Establishing and maintaining health plan  
8 quality assurance, including—

9                           “(A) quality management;

10                           “(B) credentialing;

11                           “(C) utilization management;

12                           “(D) governance;

13                           “(E) plan and quality processes;

14                           “(F) health care provider selection and due  
15 process in selection; and

16                           “(G) practice guidelines and protocols.

17                   “(2) Providing consumer protection for health  
18 plan enrollees, including—

19                           “(A) comparative consumer information  
20 with respect to health plans in a form specified  
21 in subtitle B of title XI;

22                           “(B) marketing agents and materials;

23                           “(C) nondiscrimination in plan enrollment,  
24 disenrollment and service provision;

25                           “(D) continuation of treatment with re-  
26 spect to health plans that become insolvent;

1 “(E) grievance procedures;

2 “(F) advanced directives; and

3 “(G) financial practices of health plans  
4 that interfere with quality of care.

5 “(3) Ensuring reasonable access to health care  
6 services, including—

7 “(A) ensuring that vulnerable populations  
8 have access to health care services, in accord-  
9 ance with the recommendations of the Prospec-  
10 tive Payment Assessment Commission under  
11 subsection (c);

12 “(B) anti red-lining rules; and

13 “(C) prohibition on plan discrimination  
14 against health care providers (including dis-  
15 crimination solely on the basis of the academic  
16 degree of the provider).

17 “(4) Health plan financial standards, includ-  
18 ing—

19 “(A) plan solvency requirements;

20 “(B) financial standards relating to liquid-  
21 ity, accounting and reporting; and

22 “(C) guaranty fund participation.

23 “(b) CUSTOMIZED GUIDELINES.—In establishing  
24 guidelines under subsection (a), the Secretary shall rec-

1 commend customized guidelines for the certification of dif-  
 2 ferent types of health plans, taking into consideration—

3 “(1) frontier, rural, and inner city factors; and

4 “(2) commercial insurance, managed-care plans,  
 5 and delivery-system or provider-based plans.

6 “(c) ACCESS TO VULNERABLE POPULATIONS.—Not  
 7 later than 1 year after the date of enactment of this title,  
 8 the Prospective Payment Assessment Commission shall  
 9 submit recommendations to the Secretary concerning  
 10 guidelines under subsection (a)(3)(A). In preparing such  
 11 recommendations, the Commission shall consider—

12 “(1) the anticipated impact of health care re-  
 13 form on access to health care services by individuals  
 14 in vulnerable populations; and

15 “(2) safeguards needed to ensure the continued  
 16 access to, and payment for, health care services pro-  
 17 vided to individuals in vulnerable populations.

## 18 **“Subtitle C—Expanded Access to** 19 **Health Plans**

### 20 **“PART I—ACCESS THROUGH HEALTH INSURANCE** 21 **PURCHASING COOPERATIVES**

#### 22 **“SEC. 21201. ESTABLISHMENT AND ORGANIZATION.**

23 “(a) IN GENERAL.—Individual and small group mar-  
 24 ket purchasing cooperatives (in this title referred to as  
 25 ‘purchasing cooperatives’) may be established in accord-



1   ance with this part. Each purchasing cooperative shall be  
 2   chartered under State law. An insurer may not form, un-  
 3   derwrite, or possess a majority vote of a purchasing coop-  
 4   erative, but may administer such a cooperative.

5       “(b) DUTIES OF PURCHASING COOPERATIVES.—

6           “(1) IN GENERAL.—Subject to paragraph (2),  
 7       each purchasing cooperative shall—

8           “(A) provide access to insured certified  
 9       health plans to members throughout the entire  
 10      community rating area served by the coopera-  
 11      tive;

12          “(B) enter into agreements with insured  
 13      certified health plans selected by the coopera-  
 14      tive;

15          “(C) enter into agreements with commu-  
 16      nity-rated employers located in the community  
 17      rating area served by the cooperative;

18          “(D) enroll community-rated individuals in  
 19      insured certified health plans; and

20          “(E) collect premiums from individuals en-  
 21      rolled in insured certified health plans through  
 22      the purchasing cooperative and forward such  
 23      premiums to the plans.

24          “(2) LIMITATION ON ACTIVITIES.—A purchas-  
 25      ing cooperative shall not—

1           “(A) perform any activity (including re-  
2           view, approval, or enforcement) relating to pay-  
3           ment rates for providers;

4           “(B) perform any activity (including cer-  
5           tification or enforcement) relating to compliance  
6           of insured certified health plans with the re-  
7           quirements of part I or II of subtitle B; or

8           “(C) assume financial risk in relation to  
9           any such plan.

10       “(d) RULES OF CONSTRUCTION.—

11       “(1) ESTABLISHMENT NOT REQUIRED.—Noth-  
12       ing in this section shall be construed as requiring—

13           “(A) that a purchasing cooperative be es-  
14           tablished in each community rating area; and

15           “(B) that there be only one purchasing co-  
16           operative established with respect to a commu-  
17           nity rating area.

18       “(2) SINGLE ORGANIZATION SERVING MUL-  
19       TIPLE AREAS.—Nothing in this section shall be con-  
20       strued as preventing a single entity from being the  
21       purchasing cooperative for more than one commu-  
22       nity rating area.

1           **“PART II—ACCESS THROUGH FEHBP**

2   **“SEC. 21211. SMALL BUSINESS PARTICIPATION IN FEHBP.**

3           “For access by small businesses to health benefits  
4 plans offered by the Federal Employee Health Benefits  
5 Program, see chapter 90 of title 5, United States Code.

6           **“PART III—ACCESS THROUGH ASSOCIATION**

7                               **PLANS**

8           **“Subpart A—Qualified Association Plans**

9   **“SEC. 21221. TREATMENT OF QUALIFIED ASSOCIATION**  
10                               **PLANS.**

11           “(a) GENERAL RULE.—For purposes of this title, in  
12 the case of a qualified association plan—

13                       “(1) except as otherwise provided in this sub-  
14 part, the plan shall meet all applicable requirements  
15 of this title for certified health plans offered by ex-  
16 perience-rated employers,

17                       “(2) if such plan is certified as meeting such  
18 requirements and the requirements of this subpart,  
19 such plan shall be treated as a plan established and  
20 maintained by an experience-rated employer which  
21 meets the requirements of this title for experience-  
22 rated plans, and individuals enrolled in such plan  
23 shall be treated as experience-rated individuals, and

24                       “(3) any individual who is a member of the as-  
25 sociation not enrolling in the plan shall not be treat-

1       ed as an experience-rated individual solely by reason  
2       of membership in such association.

3       “(b) ELECTION TO BE TREATED AS PURCHASING  
4 COOPERATIVE.—Subsection (a) shall not apply to a quali-  
5 fied association plan if—

6               “(1) the health plan sponsor makes an irrev-  
7 ovable election to be treated as a purchasing cooper-  
8 ative for purposes of this title, and

9               “(2) such sponsor meets all requirements of  
10 this title applicable to a purchasing cooperative.

11 **“SEC. 21222. QUALIFIED ASSOCIATION PLAN DEFINED.**

12       “(a) GENERAL RULE.—For purposes of this subpart,  
13 a plan is a qualified association plan if the plan is a mul-  
14 tiple employer welfare arrangement or similar arrange-  
15 ment—

16               “(1) which is maintained by a qualified associa-  
17 tion,

18               “(2) which has at least 500 participants in the  
19 United States,

20               “(3) under which the benefits provided consist  
21 solely of medical care (as defined in section 213(d)  
22 of the Internal Revenue Code of 1986),

23               “(4) which may not condition participation in  
24 the plan, or terminate coverage under the plan, on  
25 the basis of the health status or health claims expe-

1 rience of any employee or member or dependent of  
2 either,

3 “(5) which provides for bonding, in accordance  
4 with regulations providing rules similar to the rules  
5 under section 412 of the Employee Retirement In-  
6 come Security Act of 1974, of all persons operating  
7 or administering the plan or involved in the financial  
8 affairs of the plan, and

9 “(6) which notifies each participant or provider  
10 that it is certified as meeting the requirements of  
11 this title applicable to it.

12 “(b) SELF-INSURED PLANS.—In the case of a plan  
13 which is not fully insured (within the meaning of section  
14 514(b)(6)(D) of the Employee Retirement Income Secu-  
15 rity Act of 1974), the plan shall be treated as a qualified  
16 association plan only if—

17 “(1) the plan meets minimum financial solvency  
18 and cash reserve requirements for claims which are  
19 established by the Secretary of Labor and which  
20 shall be in lieu of any other such requirements under  
21 this title,

22 “(2) the plan provides an annual funding report  
23 (certified by an independent actuary) and annual fi-  
24 nancial statements to the Secretary of Labor and  
25 other interested parties, and

1           “(3) the plan appoints a plan sponsor who is  
2       responsible for operating the plan and ensuring com-  
3       pliance with applicable Federal and State laws.

4       “(c) CERTIFICATION.—

5           “(1) IN GENERAL.—A plan shall not be treated  
6       as a qualified association plan for any period unless  
7       there is in effect a certification by the Secretary of  
8       Labor that the plan meets the requirements of this  
9       subpart. For purposes of this title, the Secretary of  
10      Labor shall be the appropriate certifying authority  
11      with respect to the plan.

12          “(2) FEE.—The Secretary of Labor shall re-  
13      quire a \$5,000 fee for the original certification  
14      under paragraph (1) and may charge a reasonable  
15      annual fee to cover the costs of processing and re-  
16      viewing the annual statements of the plan.

17          “(3) EXPEDITED PROCEDURES.—The Secretary  
18      of Labor may by regulation provide for expedited  
19      registration, certification, and comment procedures.

20          “(4) AGREEMENTS.—The Secretary of Labor  
21      may enter into agreements with the States to carry  
22      out the Secretary’s responsibilities under this sub-  
23      part.

24          “(d) AVAILABILITY.—Notwithstanding any other  
25      provision of this title, a qualified association plan may

1 limit coverage to individuals who are members of the  
2 qualified association establishing or maintaining the plan,  
3 an employee of such member, or a spouse or dependent  
4 of either.

5 “(e) SPECIAL RULES FOR EXISTING PLANS.—In the  
6 case of a plan in existence on January 1, 1994—

7 “(1) the requirements of subsection (a) (other  
8 than paragraph (4), (5), and (6) thereof) shall not  
9 apply,

10 “(2) no original certification shall be required  
11 under this subpart, and

12 “(3) no annual report or funding statement  
13 shall be required before January 1, 1996, but the  
14 plan shall file with the Secretary of Labor a descrip-  
15 tion of the plan and the name of the plan sponsor.

16 **“SEC. 21223. DEFINITIONS AND SPECIAL RULES.**

17 “(a) QUALIFIED ASSOCIATION.—For purposes of this  
18 subpart, the term ‘qualified association’ means any organi-  
19 zation which—

20 “(1) is organized and maintained in good faith  
21 by a trade association, an industry association, a  
22 professional association, a chamber of commerce, a  
23 religious organization, a public entity association, or  
24 other business association serving a common or simi-  
25 lar industry,

1           “(2) is organized and maintained for substan-  
2           tial purposes other than to provide a health plan,

3           “(3) has a constitution, bylaws, or other similar  
4           governing document which states its purpose, and

5           “(4) receives a substantial portion of its finan-  
6           cial support from its active, affiliated, or federation  
7           members.

8           “(b) MULTIPLE EMPLOYER WELFARE ARRANGE-  
9           MENT.—For purposes of this subchapter, the term ‘mul-  
10          tiple employer welfare arrangement’ has the meaning  
11          given such term by section 3(40) of the Employee Retire-  
12          ment Income Security Act of 1974.

13          “(c) COORDINATION WITH SUBPART B.—The term  
14          ‘qualified association plan’ shall not include a plan to  
15          which subpart B applies.

16                   **“Subpart B—Special Rule for Church,**  
17                   **Multiemployer, and Cooperative Plans**

18           **“SEC. 21225. SPECIAL RULE FOR CHURCH, MULTIEM-**  
19                   **PLOYER, AND COOPERATIVE PLANS.**

20          “(a) GENERAL RULE.—For purposes of this title, in  
21          the case of a health plan to which this section applies—

22                  “(1) except as otherwise provided in this sub-  
23                  part, the plan shall be required to meet all applicable  
24                  requirements of this title for certified health plans  
25                  offered by experience-rated employers,



1           “(3) if such plan is certified as meeting such  
2 requirements, such plan shall be treated as a plan  
3 established and maintained by an experience-rated  
4 employer which meets the requirements of this title  
5 for experience-rated plans, and individuals enrolled  
6 in such plan shall be treated as experience-rated in-  
7 dividuals, and

8           “(3) any individual eligible to enroll in the plan  
9 who does not enroll in the plan shall not be treated  
10 as an experience-rated individual solely by reason of  
11 being eligible to enroll in the plan.

12       “(b) MODIFIED STANDARDS.—

13           “(1) CERTIFYING AUTHORITY.—For purposes  
14 of this title, the Secretary of Labor shall be the ap-  
15 propriate certifying authority with respect to a plan  
16 to which this section applies.

17           “(2) AVAILABILITY.—Rules similar to the rules  
18 of subsection (d) of section 21222 shall apply to a  
19 plan to which this section applies.

20           “(3) ACCESS.—An employer which, pursuant to  
21 a collective bargaining agreement, offers an em-  
22 ployee the opportunity to enroll in a plan described  
23 in subsection (c)(2) shall not be required to make  
24 any other plan available to the employee.

1           “(4) TREATMENT UNDER STATE LAWS.—A  
2 church plan described in subsection (c)(1) which is  
3 certified as meeting the requirements of this section  
4 shall not be deemed to be a multiple employer wel-  
5 fare arrangement or an insurance company or other  
6 insurer, or to be engaged in the business of insur-  
7 ance, for purposes of any State law purporting to  
8 regulate insurance companies or insurance contracts.

9           “(c) PLANS TO WHICH SECTION APPLIES.—This sec-  
10 tion shall apply to a health plan which—

11           “(1) is a church plan (as defined in section  
12 414(e) of the Internal Revenue Code of 1986) which  
13 has at least 100 participants in the United States,

14           “(2) is a multiemployer plan (as defined in sec-  
15 tion 3(37) of the Employee Retirement Income Se-  
16 curity Act of 1974) which is maintained by a health  
17 plan sponsor described in section 3(16)(B)(iii) of  
18 such Act and which has at least 500 participants in  
19 the United States, or

20           “(3) is a plan which is maintained by a rural  
21 electric cooperative or a rural telephone cooperative  
22 association (within the meaning of section 3(40) of  
23 such Act and which has at least 500 participants in  
24 the United States.

1       **“PART IV—ACCESS THROUGH EMPLOYERS**

2       **“SEC. 21231. GENERAL EMPLOYER RESPONSIBILITIES.**

3       “(a) PAYROLL DEDUCTION.—

4               “(1) IN GENERAL.—If—

5                       “(A) a certified health plan, or purchasing  
6                       cooperative on behalf of such a plan, requests  
7                       an employer under this section to withhold pre-  
8                       miums with respect to any employee enrolled in  
9                       the plan, or

10                      “(B) an employee requests an employer to  
11                      withhold premiums to a certified health plan in  
12                      which the employee is enrolled or enrolling,  
13                      the employer shall deduct and withhold such pre-  
14                      miums (less any employer contribution) through  
15                      payroll deduction and pay the amounts deducted and  
16                      withheld to the plan or to the purchasing coopera-  
17                      tive.

18               “(2) PAYROLL DEDUCTIONS.—

19                      “(A) FREQUENCY.—In the case of an em-  
20                      ployee who is paid wages or other compensa-  
21                      tion—

22                              “(i) on a monthly or more frequent  
23                              basis, the employer shall deduct and with-  
24                              hold, and pay, such premiums at the same  
25                              time as the payment of such wages or  
26                              other compensation, or

1           “(ii) less frequently than monthly, the  
2           employer shall pay such premiums on a  
3           monthly basis.

4           “(B) EMPLOYEE PROTECTIONS.—

5           “(i) WITHHOLDING CONSTITUTES  
6           SATISFACTION OF OBLIGATION.—If an em-  
7           ployee notifies the health plan sponsor that  
8           the employee has requested the employer  
9           withholding of a certain amount, the with-  
10          holding of such an amount by the employer  
11          under subparagraph (A) shall constitute  
12          satisfaction of the employee’s obligation to  
13          pay the health plan with respect to such  
14          amount.

15          “(ii) DIRECT PAYMENT ALLOWED IN  
16          CASE OF NONPAYMENT.—In the case of  
17          the nonpayment to a health plan of any  
18          amount withheld by an employer, the plan  
19          shall notify such employee of such  
20          nonpayment and shall allow the employee  
21          to make direct payments to the plan effec-  
22          tive with the next succeeding payment pe-  
23          riod.

24          “(b) TIME PERIOD FOR EMPLOYERS.—An employer  
25          shall meet the requirements of this section with respect

1 to any new employee within the 30-day period beginning  
2 on the date of hire.

3 **“SEC. 21232. DEVELOPMENT OF LARGE EMPLOYER PUR-**  
4 **CHASING GROUPS.**

5 “Nothing in this title shall be construed as prohibit-  
6 ing 2 or more experience-rated employers from joining to-  
7 gether to purchase insurance for their employees, except  
8 that each such employer shall be responsible for meeting  
9 the employer’s requirements under this title with respect  
10 to its employees.

11 **“SEC. 21233. REPORT TO EMPLOYEES ON EMPLOYER**  
12 **HEALTH CARE CONTRIBUTIONS.**

13 “Each employer with more than 25 full-time employ-  
14 ees shall report each year to each full-time employee the  
15 amount of the employer contributions made on behalf of  
16 the employee for health insurance coverage. An employer  
17 may use any reasonable means to carry out its responsibil-  
18 ities under this section (including the calculation of the  
19 amount of the employer contribution).

20 **“SEC. 21234. EMPLOYER MAY NOT DISCRIMINATE AGAINST**  
21 **SUBSIDY ELIGIBLE INDIVIDUALS.**

22 “(a) GENERAL RULE.—Any employer which elects to  
23 make employer contributions on behalf of its employees  
24 for health insurance coverage shall not condition, or vary,  
25 such contributions with respect to any employee by reason

1 of such employee's status as an individual eligible for pre-  
 2 mium assistance under subtitle B of title I of the Ameri-  
 3 ca's Health Care Option Act.

4 “(b) ELIMINATION OF CONTRIBUTIONS.—An em-  
 5 ployer shall not be treated as failing to meet the require-  
 6 ments of subsection (a) if the employer ceases to make  
 7 employer contributions for health insurance coverage for  
 8 all its employees.

9 **“SEC. 21235. ENFORCEMENT.**

10 “A State program shall provide for the monitoring  
 11 and enforcement of the requirements of this part.”.

## 12 **Subtitle B—Consolidation of** 13 **Federal Research**

14 **SEC. 211. CONSOLIDATION OF FEDERAL RESEARCH.**

15 (a) AGENCY FOR QUALITY ASSURANCE AND  
 16 CONSUMER INFORMATION.—

17 (1) IN GENERAL.—There is established within  
 18 the Department of Health and Human Services an  
 19 agency to be known as the Agency for Quality As-  
 20 surance and Consumer Information (hereafter re-  
 21 ferred to in this section as the “Agency”).

22 (2) PURPOSE.—The purpose of the Agency is to  
 23 act as the center for all Federal research activities  
 24 relating to quality and consumer information in  
 25 health care.

1           (3) ADMINISTRATOR.—There shall be at the  
2           head of the Agency an official to be known as the  
3           Administrator for Quality Assurance and Consumer  
4           Information (hereafter referred to in this section as  
5           the “Administrator”). The Administrator shall be  
6           appointed by the Secretary of Health and Human  
7           Services (hereafter referred to in this section as the  
8           “Secretary”).

9           (b) CONSOLIDATION.—

10           (1) ACTION BY SECRETARY.— The Secretary,  
11           acting through the Administrator, shall consolidate  
12           Federal research activities relating to quality and  
13           consumer information in health care through the  
14           Agency to enable States to gain access to the results  
15           of such research from a central source.

16           (2) ACTION BY ADMINISTRATOR.—The Admin-  
17           istrator shall assume the following responsibilities:

18                   (A) Responsibilities of the Administrator  
19                   for Health Care Policy and Research under title  
20                   IX of the Public Health Service Act and under  
21                   section 1142 of the Social Security Act.

22                   (B) Responsibilities of the Director of the  
23                   National Center for Health Statistics under sec-  
24                   tion 306 of the Public Health Service Act.

1 (C) Responsibilities of the Director of the  
2 Office of Medical Applications of Research at  
3 the National Institutes of Health.

4 (D) Responsibilities of the Director of the  
5 Office of Research and Demonstrations of the  
6 Health Care Financing Administration, to the  
7 extent such responsibilities relate to clinical  
8 evaluations.

9 (c) DUTIES.—

10 (1) IN GENERAL.—In carrying out subsection  
11 (b)(1), the Secretary, acting through the Adminis-  
12 trator, shall conduct and support research, dem-  
13 onstration projects, evaluations, training, guideline  
14 development, and the dissemination of information,  
15 on measures and standards of quality and consumer  
16 information relating to health care services and on  
17 systems for the delivery of such services. Activities  
18 under this section shall include—

19 (A) research with respect to the effective-  
20 ness and appropriateness of health care services  
21 and procedures;

22 (B) research with respect to quality man-  
23 agement and improvement efforts of health care  
24 systems;



1 (C) the conduct of consumer information  
2 and surveys concerning—

- 3 (i) access to care;  
4 (ii) use of health services;  
5 (iii) health outcomes; and  
6 (iv) patient satisfaction;

7 (D) the development, dissemination, appli-  
8 cation, and evaluation of practice guidelines;

9 (E) the conduct, in partnership with ex-  
10 perts, of information effectiveness trials in the  
11 private sector; and

12 (F) the systematic evaluation of existing  
13 and new treatments and diagnostic technologies  
14 in an effort to improve the knowledge base to  
15 assist in clinical decision-making and policy  
16 choices.

17 (2) EXPERTS.—The Secretary, acting through  
18 the Administrator, shall carry out the activities de-  
19 scribed in paragraph (1) in consultation with private  
20 and public experts in quality and consumer informa-  
21 tion.

22 (3) GUIDELINES.—The Administrator shall de-  
23 velop and recommend to the Secretary minimum  
24 guidelines for health care quality measures,  
25 consumer information categories, and access to

1 health services. Such guidelines shall be utilized by  
2 the Secretary in establishing guidelines for certifi-  
3 cation under part III of subtitle B of title XXI of  
4 the Social Security Act.

5 (4) DATA.—The Administrator shall rec-  
6 ommend to the Secretary standards and procedures  
7 for the administration of data and transactions re-  
8 lating to health care quality, consumer information,  
9 access, and effectiveness under subtitle B of title XI  
10 of the Social Security Act.

11 (5) RESEARCH.—The Agency shall be respon-  
12 sible for oversight with respect to basic and applied  
13 research concerning the matters described in para-  
14 graph (1).

15 (d) TRANSFERS.—There are hereby transferred to  
16 the Agency the staff, funds, and other assets of the agen-  
17 cies for which the Agency is assuming responsibilities  
18 under subsection (b)(2).

19 (e) AUTHORIZATION OF APPROPRIATIONS.—For the  
20 purpose of carrying out this section, there are authorized  
21 to be appropriated \$100,000,000 for fiscal year 1996,  
22 \$150,000,000 for fiscal year 1997, \$200,000,000 for each  
23 of the fiscal years 1998 and 1999, and \$250,000,000 for  
24 fiscal year 2000. Beginning with fiscal year 1997, at least  
25 one-third of the funds for each year shall be used for im-

1 plementing the results of quality and consumer informa-  
 2 tion research, such as grants to entities to test the use  
 3 of practice guidelines in the health care delivery system.

4 **Subtitle C—Self-Employed Individ-**  
 5 **ual and Small Employer Partici-**  
 6 **pation in Federal Employees**  
 7 **Health Benefits Plans**

8 **SEC. 221. SELF-EMPLOYED INDIVIDUAL AND SMALL EM-**  
 9 **PLOYER PARTICIPATION IN FEDERAL EM-**  
 10 **PLOYEES HEALTH BENEFITS PLANS.**

11 Part III of title 5, United States Code, is amended  
 12 by inserting after chapter 89 the following new chapter:

13 **“CHAPTER 90—SMALL BUSINESS PARTICI-**  
 14 **PATION IN FEDERAL EMPLOYEE**  
 15 **HEALTH BENEFITS PLANS**

“Sec.

“9001. Definition.

“9002. Application to small business participants.

“9003. Small business participation.

“9004. Contributions.

“9005. Continued coverage.

“9006. Schedule of small business participation.

“9007. Cost comparison reports and reductions.

16 **“§ 9001. Definition**

17 “(a) For purposes of this chapter, the term ‘small  
 18 business’ means any business entity which employs 50 or  
 19 less employees (including businesses with one self-em-  
 20 ployed individual).

1       “(b) For purposes of subsection (a), the rules under  
2 section 52 of the Internal Revenue Code of 1986 shall  
3 apply.

4       “(c) No entity, the sole purpose of which is to provide  
5 health care coverage for its members, shall be considered  
6 a small business for purposes of this chapter.

7       **“§ 9002. Application to small business participants**

8       “(a) The Office of Personnel Management shall pro-  
9 mulgate regulations to apply the provisions of chapter 89,  
10 relating to health benefits plans, to the greatest extent  
11 practicable to small businesses and individuals covered  
12 under the provisions of this chapter.

13       “(b) Notwithstanding the provisions of subsection  
14 (a), carriers shall offer the same health benefits plans for  
15 the same premiums as are offered under chapter 89.

16       “(c) Notwithstanding the provisions of subsection (a),  
17 the provisions of section 8907 shall not apply to individ-  
18 uals covered under this chapter, except the Office of Per-  
19 sonnel Management shall establish a method to dissemi-  
20 nate information relating to health benefits plans (includ-  
21 ing information concerning periods of open enrollment and  
22 a summary of the information described in section 8908)  
23 to such individuals through small business participants  
24 and carriers.

1       “(d)(1) A carrier offering a health benefits plan  
2 under this chapter may charge a fee to participating small  
3 businesses for the administrative expenses related to the  
4 enrollment of such businesses in such plan, not to exceed  
5 the lesser of—

6               “(A) 15 percent of the premiums charged each  
7 such business, or

8               “(B) the amount charged each such business of  
9 the same size.

10       “(2) A carrier shall consult with the Office of Person-  
11 nel Management before setting or adjusting any fee under  
12 this subsection.

13       “(e) A carrier offering a health benefits plan under  
14 this chapter may impose group participation requirements  
15 if such requirements are standard for all groups.

16       **“§ 9003. Small business participation**

17       “Any small business which desires to participate in  
18 a health benefits plan under this chapter may enter into  
19 a contract with a carrier in accordance with this chapter.  
20 Such contract shall provide for—

21               “(1) a term of no less than 1 year, and

22               “(2) early termination for nonpayment of pre-  
23 miums.

1 **“§ 9004. Contributions**

2 “(a) Subject to the provisions of subsection (b), an  
3 individual enrolled in a health benefits plan under this  
4 chapter shall make contributions equal to the amount of  
5 contributions made by—

6 “(1) a Federal enrollee in such plan under indi-  
7 vidual, or self and family coverage, as the case may  
8 be, as determined under section 8906;

9 “(2) the Federal agency making Government  
10 contributions determined under section 8906 for  
11 such Federal enrollee; and

12 “(3) the administrative charge applied by the  
13 carrier under section 9002(d).

14 “(b)(1) A small business may by contract agree to  
15 make any amount of the contribution required under sub-  
16 section (a) on behalf of an enrollee under such subsection.

17 “(2) An agency of a State government may provide  
18 any amount of the contribution required under subsection  
19 (a) on behalf of an enrollee under such subsection.

20 “(c) A small business participating under this chap-  
21 ter shall—

22 “(1) collect contributions from employees by  
23 withholdings from pay or by another method or  
24 schedule;

25 “(2) make payments of such contributions to  
26 the contracted carrier;

1           “(3) maintain and make available such records  
2           as the Office, applicable State insurance authority,  
3           or carrier may require; and

4           “(4) provide any other related administrative  
5           service in carrying out the provisions of this chapter.

6   **“§ 9005. Continued coverage**

7           “(a) Subject to subsection (b), the provisions of sec-  
8           tion 8905a shall be made applicable to enrollees and indi-  
9           viduals covered by such enrollments under this chapter  
10          through section 9002 and the carrier contract entered into  
11          under section 9003, except the enrollee shall pay all con-  
12          tributions for continued coverage and the applicable  
13          amount for administrative expenses unless the applicable  
14          small business by contract agrees to pay any part of such  
15          contributions or expenses.

16          “(b) An individual may be covered under continued  
17          coverage as provided under subsection (a), only if such in-  
18          dividual—

19                 “(1) was covered by a health benefits plan  
20                 under this chapter for the 2-year period immediately  
21                 preceding the date on which continued coverage  
22                 under this section begins; and

23                 “(2) remains in the same plan during the pe-  
24                 riod of continued coverage as such individual was

1 enrolled in immediately before such period of contin-  
2 ued coverage.”.

3 **“§ 9006. Schedule of small business participation**

4 “(a) Subject to the succeeding subsections of this sec-  
5 tion, each carrier enrolling individuals of small business  
6 participants under this chapter shall ensure that—

7 “(1) in the first contract year in which such  
8 carrier covers individuals of small business partici-  
9 pants, the number of enrollees from small businesses  
10 as provided under this chapter shall be no less than  
11 5 percent of the number of Federal enrollees en-  
12 rolled by such carrier under chapter 89; and

13 “(2) in the second such year, the number of  
14 small business enrollees shall be no less than 10 per-  
15 cent of the number of such Federal enrollees;

16 “(3) in the third such year, the number of  
17 small business enrollees shall be no less than 10 per-  
18 cent of the number of such Federal enrollees; and

19 “(4) in the fourth such year, the number of  
20 small business enrollees shall be no less than 10 per-  
21 cent of the number of such Federal enrollees.

22 “(b)(1) In the contract year described under sub-  
23 section (a)(1), a small business may participate if such  
24 business has between 5 and 50 employees.



1       “(2) In the contract year described under subsection  
2 (a)(2) small businesses with between 2 and 50 employees  
3 may additionally participate.

4       “(3) In the contract year described under subsection  
5 (a)(3) and each year thereafter, all small businesses may  
6 participate.

7       “(c) If during any contract year described under sub-  
8 section (a) (1) through (4), more small businesses apply  
9 for participation than are required to participate under  
10 such subsection, the carrier shall ensure that a small busi-  
11 ness shall have a priority for selection for participation  
12 if such business is not offering any type of health insur-  
13 ance benefits to its employees.

14       “(d)(1) If a carrier that enrolls individuals of small  
15 business participants under this chapter, ceases to offer  
16 enrollment to individuals under this chapter in any con-  
17 tract year, such carrier may not offer enrollment under  
18 this chapter for the following 2 contract years.

19       “(2) The provisions of paragraph (1) shall not be con-  
20 strued to require any carrier to terminate health coverage  
21 of any individual who is enrolled under this chapter at the  
22 time such carrier ceases to offer new enrollments under  
23 this chapter.

24       “(e) A small business may participate in a health ben-  
25 efits plan as provided under this section if such business

1 meets all such requirements otherwise provided under this  
2 chapter.

3 “(f) The Office may waive the requirements under  
4 subsection (a), in whole or in part, after making a deter-  
5 mination that—

6 “(1) there is insufficient interest in small busi-  
7 nesses within the region in participating under this  
8 chapter; or

9 “(2) a requirement is beyond the capacity of a  
10 carrier to enroll individuals under this chapter.

11 **“§ 9007. Cost comparison reports and reductions**

12 “(a) No later than July 1 of the first contract year  
13 implementing health care coverage under this chapter, and  
14 on July 1 of each year thereafter, each carrier contracting  
15 under chapter 89 or this chapter shall submit a report  
16 to the Office of Personnel Management that compares the  
17 aggregate cost experiences with respect to coverage be-  
18 tween—

19 “(1) Federal employees and other individuals  
20 covered under chapter 89; and

21 “(2) individuals covered under this chapter.

22 “(b) Based on the reports submitted under subsection  
23 (a), the Office may reduce the percentage requirements  
24 under section 9006(a) for any contract year (but not below  
25 the percentage of the preceding contract year).”.

1 **SEC. 222. PROHIBITION OF HEALTH BENEFITS PLANS EX-**  
2 **CLUSIVELY FOR MEMBERS AND EMPLOYEES**  
3 **OF CONGRESS.**

4 No health benefits plan under chapter 89 or 90 of  
5 title 5, United States Code, may be offered exclusively  
6 to—

7 (1) Members of Congress (including members of  
8 family);

9 (2) congressional employees as defined under  
10 section 2107 of such title (including members of  
11 family); or

12 (3) individuals described under paragraphs (1)  
13 and (2).

14 **SEC. 223. STUDY REGARDING NONWORKER AND**  
15 **NONCOVERED EMPLOYEE BUY-INS.**

16 The Secretary of Health and Human Services shall  
17 study by what method nonworkers and employees of em-  
18 ployers not covered under chapter 90 of title 5, United  
19 States Code (as added by section 221 of this Act), may  
20 be incorporated into the buy-in for coverage under the  
21 Federal Employees Health Benefits Plan. The Secretary  
22 shall report the results of such study and any appropriate  
23 legislative recommendations to the Congress not later than  
24 2 years after the date of the enactment of this Act.

1 **SEC. 224. EFFECTIVE DATE.**

2 (a) IN GENERAL.—Except as provided under sub-  
3 section (b), the provisions of this subtitle and the amend-  
4 ments made by this subtitle shall be effective on and after  
5 the first January 1 occurring after the date of the enact-  
6 ment of this Act.

7 (b) EXCEPTION.—The provisions of chapters 89 and  
8 90 of title 5, United States Code, as amended and effected  
9 by this subtitle, relating to the establishment of or exercise  
10 of authority (including the promulgation of regulations)  
11 by the Office of Personnel Management, the Secretary of  
12 Health and Human Services, the President, or any other  
13 applicable Federal officer shall take effect on the date of  
14 the enactment of this Act in order to establish health bene-  
15 fits plans and fully implement the provisions and amend-  
16 ments made by this Act no later than the first January  
17 1 occurring after the date of the enactment of this Act.

18 **Subtitle D—Report on Health Care**  
19 **System**

20 **SEC. 231. REPORT ON HEALTH CARE SYSTEM.**

21 (a) REPORT.—Not later than July 1, 1998, the Presi-  
22 dent shall submit to the Congress findings and rec-  
23 ommendations (if any) on each of the items described in  
24 subsection (b).

25 (b) ITEMS TO BE STUDIED.—The items referred to  
26 in subsection (a) are as follows:

1           (1) The characteristics of the insured and unin-  
2           sured, including demographic characteristics, work-  
3           ing status, health status, and geographic distribu-  
4           tion.

5           (2) Methods to improve access to health care  
6           and to increase health insurance coverage of the  
7           chronically uninsured.

8           (3) The effectiveness of the insurance reforms  
9           under subtitle A on access to health care and the  
10          costs of health care.

11          (4) The effectiveness of Federal efforts to as-  
12          sess the impact of new technology on the cost and  
13          availability of new products.

14          (5) The effectiveness of Federal, State, and pri-  
15          vate cost containment strategies.

16          (6) The effectiveness of Federal, State, and pri-  
17          vate efforts to measure and improve health care out-  
18          comes.

19          (7) The effectiveness of the new Federal sub-  
20          sidy programs, including recommendations to re-  
21          strain future growth.

22          (8) The effectiveness of initiatives targeted to  
23          underserved urban and rural populations.

1 **TITLE III—SPECIAL ASSISTANCE**  
2 **FOR RURAL, FRONTIER AND**  
3 **UNDERSERVED URBAN AREAS**

4 **SEC. 301. PURPOSE.**

5 It is the purpose of this title to—

6 (1) establish safeguards to assist vulnerable  
7 populations in accessing local health services and  
8 practitioners;

9 (2) provide funding to certain areas to assist  
10 health care providers and health plans in such areas  
11 in reconfiguring services and establishing networks  
12 and health plans to effectively compete in the chang-  
13 ing market;

14 (3) provide funding to increase primary care ca-  
15 pacity in underserved areas; and

16 (4) provide more flexibility in Medicare rules  
17 for health care providers in underserved areas.

18 **SEC. 302. DESIGNATED UNDERSERVED AREAS.**

19 (a) STATE DESIGNATION.—A State may designate  
20 certain rural, frontier or urban areas within the State as  
21 underserved areas based on—

22 (1) the lack of access to health plans in such  
23 areas; and

24 (2) the lack of access to quality health care pro-  
25 viders and health care facilities in such areas.

1 (b) ESTABLISHMENT OF PROCEDURE.—

2 (1) IN GENERAL.—The Secretary shall establish  
3 a procedure under which the Secretary, upon the re-  
4 quest of a State, may certify areas designated by the  
5 State under subsection (a) as underserved areas.

6 (2) NONAPPLICABILITY OF OTHER REQUIRE-  
7 MENTS.—The Secretary may certify a designated  
8 area under paragraph (1) whether or not such area  
9 meets the requirements for being considered a medi-  
10 cally underserved area or a health professional  
11 shortage area.

12 (c) EFFECT OF CERTIFICATION.—Except with re-  
13 spect to provisions in this title that explicitly direct assist-  
14 ance to those areas currently designated as underserved,  
15 in awarding grants, contracts, loans, waivers, or any other  
16 assistance under this title (or an amendment made by this  
17 title) the Secretary shall give priority to applicants that  
18 serve areas certified as underserved areas under sub-  
19 section (b).

20 (d) LIMITATION AND REVOCATION.—A certification  
21 provided under subsection (b) shall be valid for not more  
22 than 3 years. Such a certification may be revoked by the  
23 Secretary if the Secretary determines that the criteria de-  
24 scribed in paragraphs (1) and (2) of subsection (a) no  
25 longer support a certification under this section.

**Subtitle A—Planning,  
Demonstrations, and Grants**

**SEC. 311. DEMONSTRATION WAIVERS FOR THE DEVELOP-  
MENT OF HEALTH NETWORKS.**

(a) WAIVERS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary may conduct a demonstration project under which public or private entities may apply for waivers of any of the provisions of title XVIII and XIX of the Social Security Act in order to operate health networks (as defined in subsection (c)(1)) which—

(i) improve the access of medicare beneficiaries (as defined in subsection (c)(2)) and medicaid beneficiaries (as defined in subsection (c)(3)) to health care services;

(ii) improve the quality of health care services furnished to such beneficiaries;

(iii) improve the outcomes of health care services furnished to such beneficiaries; and

(iv) provide an incentive to private entities to establish networks in areas cer-



1           tified as underserved areas under section  
2           302.

3           (B) NUMBER OF WAIVERS.—The Secretary  
4           may grant waivers to operate health networks  
5           under the demonstration project conducted  
6           under this section to a number of public or pri-  
7           vate entities determined appropriate by the Sec-  
8           retary.

9           (2) APPLICATIONS.—

10          (A) IN GENERAL.—In order to participate  
11          in the demonstration project conducted under  
12          this subsection, a public or private entity desir-  
13          ing to operate a health network shall submit an  
14          application to the Secretary which meets the re-  
15          quirements of subparagraph (B). Such applica-  
16          tion shall be submitted in such manner and at  
17          such time as the Secretary shall require.

18          (B) REQUIREMENTS.—An application sub-  
19          mitted by a public or private entity under this  
20          subsection must provide—

21               (i) a description of the health care  
22               providers participating in the health net-  
23               work;

24               (ii) a description of the geographic  
25               area served by the health networks;

1 (iii) information demonstrating that  
2 the private entity has consulted with inter-  
3 ested parties with respect to the operation  
4 of the health network, including local gov-  
5 ernment entities and community groups;

6 (iv) a description of the operational  
7 structure of the health network, including  
8 whether the network is a managed care en-  
9 tity or a fee-for-service provider;

10 (v) a proposal for how payments  
11 should be made to the health network  
12 under titles XVIII and XIX of the Social  
13 Security Act, including a statement as to  
14 whether such payments should be made  
15 pursuant to the provisions of such titles or  
16 pursuant to an alternative payment meth-  
17 odology described in the application;

18 (vi) assurances that medicare bene-  
19 ficiaries served by the health network will  
20 receive care and services of the same qual-  
21 ity as the care and services received by  
22 other beneficiaries under title XVIII of the  
23 Social Security Act;

24 (vii) assurances that medicaid bene-  
25 ficiaries served by the health network will

1 receive care and services of the same qual-  
2 ity as the care and services received by  
3 other beneficiaries under title XIX of the  
4 Social Security Act;

5 (viii) a description of how the health  
6 network plans to handle any situation in  
7 which a medicare beneficiary or medicaid  
8 beneficiary served by the network receives  
9 health care services from providers outside  
10 the network;

11 (ix) assurances that the health net-  
12 work is furnishing health care services to a  
13 significant number of individuals who are  
14 not receiving benefits under titles XVIII  
15 and XIX of the Social Security Act;

16 (x) assurances that through sharing  
17 of facilities, land, and equipment, the  
18 health network will result in a reduction of  
19 total capital costs for the area served by  
20 the network;

21 (xi) a plan for cooperation in service  
22 delivery by health care providers partici-  
23 pating in the health network that dem-  
24 onstrates the elimination of unnecessary  
25 duplication and, when appropriate, the

1 consolidation of specialized services within  
2 the area served by the network;

3 (xii) evidence that the health network  
4 furnishes services which address the special  
5 access needs of the medicare beneficiaries  
6 and medicaid beneficiaries served by the  
7 network;

8 (xiii) evidence of capability and exper-  
9 tise in network planning and management;  
10 and

11 (xiv) such additional information as  
12 the Secretary determines appropriate.

13 (C) APPROVAL OF APPLICATION.—

14 (i) INITIAL REVIEW.—Within 60 days  
15 after an application is submitted by an en-  
16 tity under this subsection, the Secretary  
17 shall review and approve such application  
18 or provide the entity with a list of the  
19 modifications that are necessary for such  
20 application to be approved.

21 (ii) ADDITIONAL REVIEW.—Within 60  
22 days after an entity resubmits any applica-  
23 tion under this subsection, the Secretary  
24 shall review and approve such application  
25 or provide the entity with a summary of

1           which items included on the list provided  
2           to the State under clause (i) remain  
3           unsatisfied. An entity may resubmit an ap-  
4           plication under this subparagraph as many  
5           times as necessary to gain approval.

6           (3) COORDINATION WITH OTHER PROGRAMS.—

7       The Secretary shall coordinate the demonstration  
8       project conducted under this subsection with any  
9       other relevant Federal or State programs in order to  
10      prevent duplication and improve the quality and de-  
11      livery of health care services to medicare bene-  
12      ficiaries and medicaid beneficiaries.

13          (4) PAYMENTS TO NETWORKS.—

14            (A) IN GENERAL.—The Secretary shall de-  
15            termine the amount of payments to be made  
16            under titles XVIII and XIX to a health network  
17            participating in a demonstration project under  
18            this subsection based on historic costs adjusted  
19            based on population and geographic area as the  
20            Secretary determines appropriate to take into  
21            account the costs of furnishing health care serv-  
22            ices in the area served by the network.

23            (B) BUDGET NEUTRALITY.—The Secretary  
24            shall provide that in carrying out the dem-  
25            onstration project under this section, the aggre-

1 gate payments under titles XVIII and XIX of  
2 the Social Security Act to providers participat-  
3 ing in a health network shall be no greater or  
4 lesser than what such payments would have  
5 been if such providers were not participating in  
6 such network.

7 (5) DURATION OF WAIVERS.—Any waiver  
8 granted under the demonstration project conducted  
9 under this subsection shall be granted for a period  
10 determined appropriate by the Secretary. The Sec-  
11 retary may terminate such a waiver at any time if  
12 the Secretary determines that the health network  
13 has failed to furnish health care services in accord-  
14 ance with the terms of the waiver.

15 (6) REPORTS.—

16 (A) IN GENERAL.—Each entity receiving a  
17 waiver to operate a health network under the  
18 demonstration project conducted under this  
19 subsection shall, through an independent entity,  
20 evaluate the network and submit interim and  
21 final reports to the Secretary at such times and  
22 containing such information as the Secretary  
23 shall require.

24 (B) REPORT TO CONGRESS.—Not later  
25 than 60 days after the receipt of a final report

1 by a health network under subparagraph (A)  
2 the Secretary shall submit a report to Congress.

3 (b) DEVELOPMENTAL GRANTS.—

4 (1) IN GENERAL.—The Secretary shall award  
5 grants to entities which have received a wavier under  
6 the demonstration project conducted under sub-  
7 section (a) for the purpose of planning and develop-  
8 ing health networks.

9 (2) APPLICATION PROCESS.—

10 (A) SUBMISSION OF APPLICATION.—Each  
11 entity desiring to receive a grant under this  
12 subsection shall submit an application to the  
13 Secretary at such time and containing such in-  
14 formation as the Secretary determines appro-  
15 priate.

16 (B) CONSIDERATION OF APPLICATIONS.—  
17 The Secretary shall develop a system for deter-  
18 mining the priority for distributing grants  
19 under this subsection and such grants shall be  
20 distributed in accordance with such system.

21 (3) AUTHORIZATION OF APPROPRIATIONS.—  
22 There are authorized to be appropriated such sums  
23 as may be necessary for the purposes of awarding  
24 grants under this subsection.

25 (c) DEFINITIONS.—For purposes of this section:

1           (1) FRONTIER AREA.—The term “frontier  
2 area” means an area in which 6 or fewer individuals  
3 reside per square mile.

4           (2) HEALTH NETWORK.—The term “health net-  
5 work” means a formal cooperative arrangement be-  
6 tween participating hospitals, physicians, and other  
7 health care providers which—

8                 (A) furnishes health care services to mem-  
9 bers of the community, including medicare  
10 beneficiaries and medicaid beneficiaries;

11                (B) is located in a rural, frontier or under-  
12 served urban area; and

13                (C) is governed by a board of directors se-  
14 lected by participating health care providers.

15           (3) MEDICAID BENEFICIARY.—The term “med-  
16 icaid beneficiary” means an individual receiving ben-  
17 efits under this XIX of the Social Security Act who  
18 resides in a rural, frontier or underserved urban  
19 area or who receives health care services from a  
20 health care provider located in a rural, frontier or  
21 underserved urban area.

22           (4) MEDICARE BENEFICIARY.—The term “med-  
23 icare beneficiary” means an individual receiving ben-  
24 efits under title XVIII of the Social Security Act  
25 who resides in a rural, frontier or underserved urban



1 area or who receives health care services from a  
 2 health care provider located in a rural, frontier or  
 3 underserved urban area.

4 (5) RURAL AREA.—The term “rural area”  
 5 means a rural area as described in section  
 6 1886(d)(2)(D) of the Social Security Act.

7 (6) UNDERSERVED URBAN AREA.—The term  
 8 “underserved urban area” means an area (other  
 9 than a rural area) determined to be underserved by  
 10 the Secretary.

11 **SEC. 312. GRANTS FOR THE PLANNING OF HEALTH NET-**  
 12 **WORKS OR HEALTH PLANS.**

13 Title XX of the Social Security Act (42 U.S.C. 1397  
 14 et seq.) is amended—

15 (1) in the title heading, by adding at the end  
 16 thereof the following: “AND MISCELLANEOUS  
 17 PROVISIONS”;

18 (2) by inserting after the title heading the fol-  
 19 lowing:

20 **“Subtitle A—Block Grants”; and**

21 (3) by adding at the end thereof the following:

1 **“Subtitle B—Health Plans and Net-**  
2 **works Initiated by Private Enti-**  
3 **ties**

4 “GRANTS FOR THE PLANNING OF HEALTH NETWORKS  
5 AND HEALTH PLANS

6 “SEC. 2011. (a) IN GENERAL.—The Secretary shall  
7 award grants to private entities submitting applications  
8 that are approved under subsection (b) for the purpose  
9 of planning and developing health networks or health  
10 plans to serve underserved areas certified under section  
11 302 of the America’s Health Care Option Act.

12 “(b) APPLICATION PROCESS.—

13 “(1) SUBMISSION OF APPLICATION.—Each pri-  
14 vate entity desiring to receive a grant under this sec-  
15 tion shall submit an application to the Secretary at  
16 such time and containing such information as the  
17 Secretary determines appropriate, including—

18 “(A) a description of the health care pro-  
19 viders that will participate in the health net-  
20 work or serve through the health plan;

21 “(B) a description of the geographic area  
22 to be served by the health network or plan;

23 “(C) information demonstrating that the  
24 private entity has consulted with interested par-  
25 ties with respect to the operation of the health

1 network or plan, including local government en-  
2 tities and community groups;

3 “(D) a description of the operational struc-  
4 ture of the health network or plan, including  
5 whether the network is a managed care entity  
6 or a fee-for-service provider;

7 “(E) assurances that through sharing of  
8 facilities, land, and equipment, the health net-  
9 work will result in a reduction of total capital  
10 costs for the area served by the network;

11 “(F) a plan for cooperation in service de-  
12 livery by health care providers participating in  
13 the health network or plan that demonstrates  
14 the elimination of unnecessary duplication and,  
15 when appropriate, the consolidation of special-  
16 ized services within the area served by the net-  
17 work or plan;

18 “(G) evidence that the health network will  
19 furnish services which address the special ac-  
20 cess needs of the individuals served by the net-  
21 work;

22 “(H) a demonstration that the health plan  
23 developed will improve access to services for the  
24 community served; and

1           “(I) evidence of capability and expertise in  
 2           network planning, health plans and manage-  
 3           ment.

4           “(2) CONSIDERATION OF APPLICATIONS.—The  
 5           Secretary shall develop a system for determining the  
 6           priority for distributing grants under this section  
 7           and such grants shall be distributed in accordance  
 8           with such system.

9           “(c) AUTHORIZATION OF APPROPRIATIONS.—There  
 10          are authorized to be appropriated such sums as may be  
 11          necessary for the purposes of awarding grants under this  
 12          section.

13          “(d) DEFINITIONS.—For purposes of this section, the  
 14          term “health network” has the same meaning given such  
 15          term in section 311(c)(1) of the America’s Health Care  
 16          Option Act.”.

17       **SEC. 313. COMMUNITY-BASED PRIMARY HEALTH CARE**  
 18               **GRANT PROGRAM.**

19          Subpart I of part D of title III of the Public Health  
 20          Service Act (42 U.S.C. 254b et seq.) is amended by adding  
 21          at the end the following new section:

22       **“SEC. 330A. COMMUNITY-BASED PRIMARY HEALTH CARE**  
 23               **GRANT PROGRAM.**

24          “(a) ESTABLISHMENT.—The Secretary shall estab-  
 25          lish and administer a program to provide allotments to

1 States to enable such States to provide grants for the cre-  
2 ation or enhancement of community-based primary health  
3 care entities that provide services to low-income or medi-  
4 cally underserved populations.

5 “(b) ALLOTMENTS TO STATES.—

6 “(1) IN GENERAL.—From the amount available  
7 for allotment under subsection (h) for a fiscal year,  
8 the Secretary shall allot to each State an amount  
9 equal to the product of the grant share of the State  
10 (as determined under paragraph (2)) multiplied by  
11 such amount available.

12 “(2) GRANT SHARE.—

13 “(A) IN GENERAL.—For purposes of para-  
14 graph (1), the grant share of a State shall be  
15 the product of the need-adjusted population of  
16 the State (as determined under subparagraph  
17 (B)) multiplied by the Federal matching per-  
18 centage of the State (as determined under sub-  
19 paragraph (C)), expressed as a percentage of  
20 the sum of the products of such factors for all  
21 States.

22 “(B) NEED-ADJUSTED POPULATION.—

23 “(i) IN GENERAL.—For purposes of  
24 subparagraph (A), the need-adjusted popu-  
25 lation of a State shall be the product of

1 the total population of the State (as esti-  
2 mated by the Secretary of Commerce) mul-  
3 tiplied by the need index of the State (as  
4 determined under clause (ii)).

5 “(ii) NEED INDEX.—For purposes of  
6 clause (i), the need index of a State shall  
7 be the ratio of—

8 “(I) the weighted sum of the geo-  
9 graphic percentage of the State (as  
10 determined under clause (iii)), the  
11 poverty percentage of the State (as  
12 determined under clause (iv)), and the  
13 multiple grant percentage of the State  
14 (as determined under clause (v)); to

15 “(II) the general population per-  
16 centage of the State (as determined  
17 under clause (vi)).

18 “(iii) GEOGRAPHIC PERCENTAGE.—

19 “(I) IN GENERAL.—For purposes  
20 of clause (ii)(I), the geographic per-  
21 centage of the State shall be the esti-  
22 mated population of the State that is  
23 residing in nonurbanized areas (as de-  
24 termined under subclause (II)) ex-

1 pressed as a percentage of the total  
2 nonurbanized population of all States.

3 “(II) NONURBANIZED POPU-  
4 LATION.—For purposes of subclause  
5 (I), the estimated population of the  
6 State that is residing in nonurbanized  
7 areas shall be one minus the urban-  
8 ized population of the State (as deter-  
9 mined using the most recent decennial  
10 census), expressed as a percentage of  
11 the total population of the State (as  
12 determined using the most recent de-  
13 cennial census), multiplied by the cur-  
14 rent estimated population of the  
15 State.

16 “(III) STATE OF ALASKA.—Not-  
17 withstanding subclause (I), the geo-  
18 graphic percentage for the State of  
19 Alaska shall be the relative population  
20 density of the State expressed as the  
21 ratio of—

22 “(aa) the average number of  
23 individuals residing in Alaska per  
24 square mile; to

1                   “(bb) the average number of  
2                   individuals residing in the United  
3                   States per square mile.

4                   “(iv) POVERTY PERCENTAGE.—For  
5                   purposes of clause (ii)(I), the poverty per-  
6                   centage of the State shall be the estimated  
7                   number of people residing in the State  
8                   with incomes below 200 percent of the in-  
9                   come official poverty line (as adjusted for  
10                  actual costs and incomes in each State and  
11                  as determined by the Office of Manage-  
12                  ment and Budget) expressed as a percent-  
13                  age of the total number of such people re-  
14                  siding in all States.

15                  “(v) MULTIPLE GRANT PERCENT-  
16                  AGE.—For purposes of clause (ii)(I), the  
17                  multiple grant percentage of the State  
18                  shall be the amount of Federal funding re-  
19                  ceived by the State under grants awarded  
20                  under sections 329, 330, and 340, ex-  
21                  pressed as a percentage of the total  
22                  amounts received under such grants by all  
23                  States. With respect to a State, such per-  
24                  centage shall not exceed twice the general  
25                  population percentage of the State under



1 clause (vi) or be less than one-half of the  
2 States general population percentage.

3 “(vi) GENERAL POPULATION PER-  
4 CENTAGE.—For purposes of clause (ii)(II),  
5 the general population percentage of the  
6 State shall be the total population of the  
7 State (as determined by the Secretary of  
8 Commerce) expressed as a percentage of  
9 the total population of all States.

10 “(C) FEDERAL MATCHING PERCENTAGE.—

11 “(i) IN GENERAL.—For purposes of  
12 subparagraph (A), the Federal matching  
13 percentage of the State shall be equal to  
14 one, less the State matching percentage (as  
15 determined under clause (ii)).

16 “(ii) STATE MATCHING PERCENT-  
17 AGE.—For purposes of clause (i), the State  
18 matching percentage of the State shall be  
19 0.25 multiplied by the ratio of the total  
20 taxable resource percentage (as determined  
21 under clause (iii)) to the need-adjusted  
22 population of the State (as determined  
23 under subparagraph (B)).

24 “(iii) TOTAL TAXABLE RESOURCE  
25 PERCENTAGE.—For purposes of clause (ii),

1           the total taxable resources percentage of  
2           the State shall be the total taxable re-  
3           sources of a State (as determined by the  
4           Secretary of the Treasury) expressed as a  
5           percentage of the sum of the total taxable  
6           resources of all States.

7           “(3) ANNUAL ESTIMATES.—

8           “(A) IN GENERAL.—If the Secretary of  
9           Commerce does not produce the annual esti-  
10          mates required under paragraph (2)(B)(iv),  
11          such estimates shall be determined by multiply-  
12          ing the percentage of the population of the  
13          State that is below 200 percent of the income  
14          official poverty line as determined using the  
15          most recent decennial census by the most recent  
16          estimate of the total population of the State.  
17          Except as provided in subparagraph (B), the  
18          calculations required under this subparagraph  
19          shall be made based on the most recent 3-year  
20          average of the total taxable resources of individ-  
21          uals within the State.

22          “(B) DISTRICT OF COLUMBIA.—Notwith-  
23          standing subparagraph (A), the calculations re-  
24          quired under such subparagraph with respect to  
25          the District of Columbia shall be based on the

1       most recent 3-year average of the personal in-  
 2       come of individuals residing within the District  
 3       as a percentage of the personal income for all  
 4       individuals residing within the District, as de-  
 5       termined by the Secretary of Commerce.

6               “(C) STATE OF ALASKA.—Notwithstanding  
 7       subparagraph (A), the calculations required  
 8       under such subparagraph with respect to the  
 9       State of Alaska shall be based on the quotient  
 10      of—

11                   “(i) the most recent 3-year average of  
 12                   the per capita income of individuals resid-  
 13                   ing in the State; divided by

14                   “(ii) 1.25.

15               “(4) MATCHING REQUIREMENT.—A State that  
 16       receives an allotment under this section shall make  
 17       available State resources (either directly or indi-  
 18       rectly) to carry out this section in an amount that  
 19       shall equal the State matching percentage for the  
 20       State (as determined under paragraph (2)(C)(ii)) di-  
 21       vided by the Federal matching percentage (as deter-  
 22       mined under paragraph (2)(C)).

23               “(c) APPLICATION.—

24               “(1) IN GENERAL.—To be eligible to receive an  
 25       allotment under this section, a State shall prepare

1 and submit an application to the Secretary at such  
2 time, in such manner, and containing such informa-  
3 tion as the Secretary may by regulation require.

4 “(2) ASSURANCES.—A State application sub-  
5 mitted under paragraph (1) shall contain an assur-  
6 ance that—

7 “(A) the State will use amounts received  
8 under its allotment consistent with the require-  
9 ments of this section; and

10 “(B) the State will provide, from non-Fed-  
11 eral sources, the amounts required under sub-  
12 section (b)(4).

13 “(d) USE OF FUNDS.—

14 “(1) IN GENERAL.—The State shall use  
15 amounts received under this section to award grants  
16 to eligible public and nonprofit private entities, or  
17 consortia of such entities, within the State to enable  
18 such entities or consortia to provide services of the  
19 type described in paragraph (2) of section 329(h) to  
20 low-income or medically underserved populations.

21 “(2) ELIGIBILITY.—To be eligible to receive a  
22 grant under paragraph (1), an entity or consortium  
23 shall—

24 “(A) prepare and submit to the admin-  
25 istering entity of the State, an application at

1 such time, in such manner, and containing such  
2 information as such administering entity may  
3 require, including a plan for the provision of  
4 services of the type described in paragraph (3);

5 “(B) provide assurances that services will  
6 be provided under the grant at fee rates estab-  
7 lished or determined in accordance with section  
8 330(e)(3)(F); and

9 “(C) provide assurances that in the case of  
10 services provided to individuals with health in-  
11 surance, such insurance shall be used as the  
12 primary source of payment for such services.

13 “(3) SERVICES.—The services to be provided  
14 under a grant awarded under paragraph (1) shall in-  
15 clude—

16 “(A) one or more of the types of primary  
17 health services described in section 330(b)(1);

18 “(B) one or more of the types of supple-  
19 mental health services described in section  
20 330(b)(2); and

21 “(C) any other services determined appro-  
22 priate by the administering entity of the State.

23 “(4) TARGET POPULATIONS.—Entities or con-  
24 sortia receiving grants under paragraph (1) shall, in  
25 providing the services described in paragraph (3),

1 substantially target populations of low-income or  
2 medically underserved populations within the State  
3 who reside in medically underserved or health pro-  
4 fessional shortage areas, areas certified as under-  
5 served under the rural health clinic program, or  
6 other areas determined appropriate by the admin-  
7 istering entity of the State, within the State.

8 “(5) PRIORITY.—In awarding grants under  
9 paragraph (1), the State shall—

10 “(A) give priority to entities or consortia  
11 that can demonstrate through the plan submit-  
12 ted under paragraph (2) that—

13 “(i) the services provided under the  
14 grant will expand the availability of pri-  
15 mary care services to the maximum num-  
16 ber of low-income or medically underserved  
17 populations who have no access to such  
18 care on the date of the grant award; and

19 “(ii) the delivery of services under the  
20 grant will be cost-effective; and

21 “(B) ensure that an equitable distribution  
22 of funds is achieved among urban and rural en-  
23 tities or consortia.

24 “(e) REPORTS AND AUDITS.—Each State shall pre-  
25 pare and submit to the Secretary annual reports concern-

1 ing the State's activities under this section which shall be  
2 in such form and contain such information as the Sec-  
3 retary determines appropriate. Each such State shall es-  
4 tablish fiscal control and fund accounting procedures as  
5 may be necessary to assure that amounts received under  
6 this section are being disbursed properly and are ac-  
7 counted for, and include the results of audits conducted  
8 under such procedures in the reports submitted under this  
9 subsection.

10 “(f) PAYMENTS.—

11 “(1) ENTITLEMENT.—Each State for which an  
12 application has been approved by the Secretary  
13 under this section shall be entitled to payments  
14 under this section for each fiscal year in an amount  
15 not to exceed the State's allotment under subsection  
16 (b) to be expended by the State in accordance with  
17 the terms of the application for the fiscal year for  
18 which the allotment is to be made.

19 “(2) METHOD OF PAYMENTS.—The Secretary  
20 may make payments to a State in installments, and  
21 in advance or by way of reimbursement, with nec-  
22 essary adjustments on account of overpayments or  
23 underpayments, as the Secretary may determine.

24 “(3) STATE SPENDING OF PAYMENTS.—Pay-  
25 ments to a State from the allotment under sub-

1       section (b) for any fiscal year must be expended by  
2       the State in that fiscal year or in the succeeding fis-  
3       cal year.

4       “(g) DEFINITION.—As used in this section, the term  
5       ‘administering entity of the State’ means the agency or  
6       official designated by the chief executive officer of the  
7       State to administer the amounts provided to the State  
8       under this section.

9       “(h) FUNDING.—Notwithstanding any other provi-  
10      sion of law, the Secretary shall use 50 percent of the  
11      amounts that the Secretary is required to utilize under  
12      section 330B(h) in each fiscal year to carry out this sec-  
13      tion.”.

## 14       **Subtitle B—Technical Assistance** 15                                   **Grants**

### 16      **SEC. 321. TECHNICAL ASSISTANCE GRANTS.**

17       (a) IN GENERAL.—The Secretary shall award grants  
18      to public and private entities submitting applications that  
19      are approved under subsection (b) for the purpose of pro-  
20      viding technical assistance in the establishment of the in-  
21      frastructure for health networks and plans in underserved  
22      areas certified under section 302.

23       (b) APPLICATION PROCESS.—

24               (1) SUBMISSION OF APPLICATION.—Each entity  
25      desiring to receive a grant under this section shall



1 submit an application to the Secretary at such time  
2 and containing such information as the Secretary  
3 determines appropriate, including—

4 (A) a description of the infrastructure uses  
5 to which amounts awarded under a grant will  
6 be allocated;

7 (B) a description of the area to be served  
8 by the entity; and

9 (C) information demonstrating that the en-  
10 tity has consulted with interested parties with  
11 respect to the activities that the entity intends  
12 to carry out with amounts received under the  
13 grant, including local government entities and  
14 community groups.

15 (2) CONSIDERATION OF APPLICATIONS.—The  
16 Secretary shall develop a system for determining the  
17 priority for distributing grants under this section  
18 and such grants shall be distributed in accordance  
19 with such system. The Secretary shall give priority  
20 to applications that demonstrate partnerships among  
21 health care providers and services (both public and  
22 private) and effective coordination of all sources of  
23 grants and other funding sources under this Act.

24 (c) AUTHORIZED USES.—Amounts received under a  
25 grant awarded under this section may be used—

1           (1) for the design and establishment of the in-  
2       frastructure necessary for the operation of a health  
3       network or health plan in a rural, frontier or urban  
4       underserved area;

5           (2) to assist health plans operating in rural,  
6       frontier or urban underserved areas in meeting the  
7       requirements of any subsidy program;

8           (3) to carry out activities to assist health care  
9       providers in forming partnerships or health plans to  
10      serve rural, frontier or urban underserved areas, in-  
11      cluding assistance with the establishment of finan-  
12      cial systems, computer systems, and telecommuni-  
13      cations systems; and

14          (4) to carry out any other activity determined  
15      appropriate by the Secretary.

16      (d) AUTHORIZATION OF APPROPRIATIONS.—There  
17   are authorized to be appropriated such sums as may be  
18   necessary for the purposes of awarding grants under this  
19   section.

20      (e) DEFINITIONS.—For purposes of this section, the  
21   terms “health network”, “rural area”, “frontier area”,  
22   and “urban underserved area” have the same meanings  
23   given such terms in section 311(c).

1       **Subtitle C—Capital Assistance**  
2       **Loans and Loan Guarantees**

3       **SEC. 331. RURAL, FRONTIER AND URBAN UNDERSERVED**  
4               **AREA HEALTH LOAN PROGRAM.**

5           (a) IN GENERAL.—The Secretary shall make loans  
6 to—

7               (1) health networks (as defined in section  
8       311(c));

9               (2) health plans (as defined in section 21003(a)  
10       of the Social Security Act) that cover individuals re-  
11       siding in rural, frontier or urban underserved areas;  
12       or

13               (3) health care providers that serve rural, fron-  
14       tier or underserved urban areas;

15 for the capital costs of developing health delivery systems  
16 and expanding existing health delivery sites to make  
17 health care services available to individuals residing in un-  
18 derserved areas certified under section 302.

19       (b) USE OF ASSISTANCE.—

20           (1) IN GENERAL.—The capital costs for which  
21       loans made pursuant to subsection (a) may be ex-  
22       pended are, subject to paragraphs (2) and (3), the  
23       following:

24               (A) The modernization or expansion of fa-  
25       cilities to reduce the inpatient characteristics of

1 such facilities while expanding the ambulatory  
2 capabilities of such facilities, to enhance the  
3 provision and accessibility of health care serv-  
4 ices and practitioners to underserved popu-  
5 lations.

6 (B) The conversion of unneeded facilities  
7 to facilities that will assure or enhance the pro-  
8 vision and accessibility of health care services  
9 and practitioners to underserved populations, or  
10 the closure of such facilities in an effort to con-  
11 solidate clinical and administrative activities for  
12 network purposes.

13 (C) The acquisition or modernization of fa-  
14 cilities or purchase of land to facilitate the serv-  
15 ice of rural, frontier and urban underserved  
16 populations through health care networks or  
17 health plans.

18 (D) The purchase of major equipment, in-  
19 cluding equipment necessary for the support of  
20 information systems, for the operation of a  
21 health care network or a health care plan serv-  
22 ing residents of rural, frontier and urban un-  
23 derserved areas.

24 (E) The development and implementation  
25 of systems (financial, quality assurance and

1 other systems) necessary to establish health  
2 care networks.

3 (F) The development of appropriate pri-  
4 mary care services and practitioners.

5 (G) The implementation of measures nec-  
6 essary to enable a health care network, health  
7 plan, or health care provider that serves rural,  
8 frontier or urban underserved areas to comply  
9 with applicable quality, safety or environmental  
10 requirements.

11 (H) Such other capital costs as the Sec-  
12 retary may determine are necessary to achieve  
13 the objectives of this section, including start-up  
14 expenses, reserve funds, and other financial re-  
15 quirements applicable to networks, plans or pro-  
16 viders.

17 (2) PRIORITIES REGARDING USE OF FUNDS.—

18 In providing loans under subsection (a) for an en-  
19 tity, the Secretary shall give priority to authorizing  
20 the use of amounts for projects for the renovation  
21 and modernization of medical facilities necessary to  
22 prevent or eliminate safety hazards, avoid non-  
23 compliance with licensure or accreditation standards,  
24 or projects to replace obsolete facilities.

1           (3) LIMITATION.—The Secretary may authorize  
2           the use of loans under subsection (a) for the con-  
3           struction of new buildings only if the Secretary de-  
4           termines that appropriate facilities are not available  
5           through acquiring, modernizing, expanding or con-  
6           verting existing buildings, or that construction new  
7           buildings will cost less.

8           (c) AMOUNT OF ASSISTANCE.—The principal amount  
9           of loans under subsection (a) may cover up to 100 percent  
10          of the costs involved.

11   **SEC. 332. CERTAIN REQUIREMENTS.**

12          (a) IN GENERAL.—The Secretary may approve a loan  
13          under section 331 only if—

14               (1) an application for such assistance is submit-  
15               ted to the Secretary in such form, is made in such  
16               manner, and contains such agreements, assurances,  
17               and information as the Secretary determines to be  
18               necessary to carry out this subtitle;

19               (2) the Secretary is reasonably satisfied that  
20               the applicant for the project for which the loan  
21               would be made will be able to make payments of  
22               principal and interest thereon when due; and

23               (3) the applicant provides the Secretary with  
24               reasonable assurances that there will be available to  
25               it such additional funds as may be necessary to com-

1       plete the project or undertaking with respect to  
2       which such loan is requested.

3       (b) TERMS AND CONDITIONS.—Any loan made under  
4 section 331 shall, subject to the Federal Credit Reform  
5 Act of 1990, meet such terms and conditions (including  
6 provisions for recovery in case of default) as the Secretary,  
7 in consultation with the Secretary of the Treasury, deter-  
8 mines to be necessary to carry out the purposes of such  
9 section while adequately protecting the financial interests  
10 of the United States. Terms and conditions for such loans  
11 shall include provisions regarding the following:

12               (1) Security.

13               (2) Maturity date.

14               (3) Amount and frequency of installments.

15               (4) Rate of interest, which shall be at a rate  
16 comparable to the rate of interest prevailing on the  
17 date the loan is made.

18 **SEC. 333. DEFAULTS.**

19       (a) IN GENERAL.—The Secretary may take such ac-  
20 tion as may be necessary to prevent a default on loans  
21 under section 331, including the waiver of regulatory con-  
22 ditions, deferral of loan payments, renegotiation of loans,  
23 and the expenditure of funds for technical and consultative  
24 assistance, for the temporary payment of the interest and  
25 principal on such a loan, and for other purposes.

1 (b) FORECLOSURE.—The Secretary may take such  
 2 action, consistent with State law respecting foreclosure  
 3 procedures, as the Secretary deems appropriate to protect  
 4 the interest of the United States in the event of a default  
 5 on a loan made pursuant to section 331, including selling  
 6 real property pledged as security for such a loan and for  
 7 a reasonable period of time taking possession of, holding,  
 8 and using real property pledged as security for such a  
 9 loan.

10 (c) WAIVERS.—The Secretary may, for good cause,  
 11 but with due regard to the financial interests of the United  
 12 States, waive any right of recovery which the Secretary  
 13 has by reasons of the failure of a borrower to make pay-  
 14 ments of principal of and interest on a loan made pursu-  
 15 ant to section 331, except that if such loan is sold and  
 16 guaranteed, any such waiver shall have no effect upon the  
 17 Secretary's guarantee of timely payment of principal and  
 18 interest.

## 19 **Subtitle D—Increasing Primary** 20 **Care Providers**

### 21 **SEC. 341. NONREFUNDABLE CREDIT FOR CERTAIN PRI-** 22 **MARY HEALTH SERVICES PROVIDERS.**

23 (a) IN GENERAL.—Subpart A of part IV of sub-  
 24 chapter A of chapter 1 of the Internal Revenue Code of  
 25 1986 (relating to nonrefundable personal credits) is



1 amended by inserting after section 22 the following new  
2 section:

3 **“SEC. 23. PRIMARY HEALTH SERVICES PROVIDERS.**

4 “(a) ALLOWANCE OF CREDIT.—There shall be al-  
5 lowed as a credit against the tax imposed by this chapter  
6 for the taxable year an amount equal to the product of—

7 “(1) the number of months during such taxable  
8 year—

9 “(A) during which the taxpayer is a quali-  
10 fied primary health services provider, and

11 “(B) which are within the taxpayer’s man-  
12 datory service period, and

13 “(2) \$1,000 (\$500 in the case of a qualified  
14 practitioner who is not a physician).

15 “(b) QUALIFIED PRIMARY HEALTH SERVICES PRO-  
16 VIDER.—For purposes of this section, the term ‘qualified  
17 primary health services provider’ means, with respect to  
18 any month, any qualified practitioner who—

19 “(1) has in effect a certification by the Bureau  
20 as a provider of primary health services and such  
21 certification is, when issued, for a health profes-  
22 sional shortage area in which the qualified practi-  
23 tioner is commencing the providing of primary  
24 health services,

1           “(2) is providing primary health services full  
2           time in the health professional shortage area identi-  
3           fied in such certification, and

4           “(3) has not received a scholarship under the  
5           National Health Service Corps Scholarship Program  
6           or any loan repayments under the National Health  
7           Service Corps Loan Repayment Program.

8           For purposes of paragraph (2) and subsection (e)(3), a  
9           provider shall be treated as providing services in a health  
10          professional shortage area when such area ceases to be  
11          such an area if it was such an area when the provider  
12          commenced providing services in the area.

13          “(c) MANDATORY SERVICE PERIOD.—For purposes  
14          of this section, the term ‘mandatory service period’ means  
15          the period of 60 consecutive calendar months beginning  
16          with the first month the taxpayer is a qualified primary  
17          health services provider. A taxpayer shall not have more  
18          than 1 mandatory service period.

19          “(d) DEFINITIONS AND SPECIAL RULES.—For pur-  
20          poses of this section—

21                 “(1) BUREAU.—The term ‘Bureau’ means the  
22                 Bureau of Primary Health Care, Health Resources  
23                 and Services Administration of the United States  
24                 Public Health Service.

1           “(2) QUALIFIED PRACTITIONER.—The term  
2           ‘qualified practitioner’ means a physician, a physi-  
3           cian assistant, a nurse practitioner, or a certified  
4           nurse-midwife.

5           “(3) PHYSICIAN.—The term ‘physician’ has the  
6           meaning given to such term by section 1861(r) of  
7           the Social Security Act.

8           “(4) PHYSICIAN ASSISTANT; NURSE PRACTI-  
9           TIONER.—The terms ‘physician assistant’ and ‘nurse  
10          practitioner’ have the meanings given to such terms  
11          by section 1861(aa)(5) of the Social Security Act.

12          “(5) CERTIFIED NURSE-MIDWIFE.—The term  
13          ‘certified nurse-midwife’ has the meaning given to  
14          such term by section 1861(gg)(2) of the Social Secu-  
15          rity Act.

16          “(6) PRIMARY HEALTH SERVICES.—The term  
17          ‘primary health services’ has the meaning given such  
18          term by section 330(b)(1) of the Public Health Serv-  
19          ice Act.

20          “(7) HEALTH PROFESSIONAL SHORTAGE  
21          AREA.—The term ‘health professional shortage area’  
22          has the meaning given such term by section  
23          332(a)(1)(A) of the Public Health Service Act.

24          “(e) RECAPTURE OF CREDIT.—

“(1) IN GENERAL.—If there is a recapture event during any taxable year, then—

“(A) no credit shall be allowed under subsection (a) for such taxable year and any succeeding taxable year, and

“(B) the tax of the taxpayer under this chapter for such taxable year shall be increased by an amount equal to the product of—

“(i) the applicable percentage, and

“(ii) the aggregate unrecaptured credits allowed to such taxpayer under this section for all prior taxable years.

“(2) APPLICABLE RECAPTURE PERCENTAGE.—

“(A) IN GENERAL.—For purposes of this subsection, the applicable recapture percentage shall be determined from the following table:

<b>“If the recapture event occurs during:</b>	<b>The applicable recapture percentage is:</b>
Months 1–24 .....	100
Months 25–36 .....	75
Months 37–48 .....	50
Months 49–60 .....	25
Month 61 or thereafter .....	0.

“(B) TIMING.—For purposes of subparagraph (A), month 1 shall begin on the first day of the mandatory service period.

“(3) RECAPTURE EVENT DEFINED.—

“(A) IN GENERAL.—For purposes of this subsection, the term ‘recapture event’ means

1 the failure of the taxpayer to be a qualified pri-  
 2 mary health services provider for any month  
 3 during the taxpayer's mandatory service period.

4 “(B) SECRETARIAL WAIVER.—The Sec-  
 5 retary, in consultation with the Secretary of  
 6 Health and Human Services, may waive any re-  
 7 capture event caused by extraordinary cir-  
 8 cumstances.

9 “(4) NO CREDITS AGAINST TAX; MINIMUM  
 10 TAX.—Any increase in tax under this subsection  
 11 shall not be treated as a tax imposed by this chapter  
 12 for purposes of determining the amount of any cred-  
 13 it under subpart A, B, or D of this part or for pur-  
 14 poses of section 55.”

15 (b) CLERICAL AMENDMENT.—The table of sections  
 16 for subpart A of part IV of subchapter A of chapter 1  
 17 of such Code is amended by inserting after the item relat-  
 18 ing to section 22 the following new item:

“Sec. 23. Primary health services providers.”

19 (c) EFFECTIVE DATE.—The amendments made by  
 20 this section shall apply to taxable years beginning after  
 21 December 31, 1994.

22 **SEC. 342. EXPENSING OF MEDICAL EQUIPMENT.**

23 (a) IN GENERAL.—Paragraph (1) of section 179(b)  
 24 of the Internal Revenue Code of 1986 (relating to dollar

1 limitation on expensing of certain depreciable business as-  
2 sets) is amended to read as follows:

3 “(1) DOLLAR LIMITATION.—

4 “(A) GENERAL RULE.—The aggregate cost  
5 which may be taken into account under sub-  
6 section (a) for any taxable year shall not exceed  
7 \$17,500.

8 “(B) HEALTH CARE PROPERTY.—The ag-  
9 gregate cost which may be taken into account  
10 under subsection (a) shall be increased by the  
11 lesser of—

12 “(i) the cost of section 179 property  
13 which is health care property placed in  
14 service during the taxable year, or

15 “(ii) \$10,000.”

16 (b) DEFINITION.—Section 179(d) of such Code (re-  
17 lating to definitions) is amended by adding at the end the  
18 following new paragraph:

19 “(11) HEALTH CARE PROPERTY.—For purposes  
20 of this section, the term ‘health care property’  
21 means section 179 property—

22 “(A) which is medical equipment used in  
23 the screening, monitoring, observation, diag-  
24 nosis, or treatment of patients in a laboratory,  
25 medical, or hospital environment,

1           “(B) which is owned (directly or indirectly)  
2           and used by a physician (as defined in section  
3           1861(r) of the Social Security Act) in the active  
4           conduct of such physician’s full-time trade or  
5           business of providing primary health services  
6           (as defined in section 330(b)(1) of the Public  
7           Health Service Act) in a health professional  
8           shortage area (as defined in section  
9           332(a)(1)(A) of the Public Health Service Act),  
10          and

11           “(C) substantially all the use of which is in  
12          such area.”

13          (c) RECAPTURE.—Paragraph (10) of section 179(d)  
14 of such Code is amended by inserting before the period  
15 “and with respect to any health care property which ceases  
16 (other than by an area failing to be treated as a health  
17 professional shortage area) to be health care property at  
18 any time”.

19          (d) EFFECTIVE DATE.—The amendments made by  
20 this section shall apply to property placed in service in  
21 taxable years beginning after December 31, 1994.

22 **SEC. 343. EXPANDED SERVICES FOR MEDICALLY UNDER-**  
23 **SERVED INDIVIDUALS.**

24          (a) IN GENERAL.—Subpart I of part D of title III  
25 of the Public Health Service Act (42 U.S.C. 254b et seq.)

1 (as amended by section 313) is amended by adding at the  
2 end the following new section:

3 **“SEC. 330B. EXPANDED SERVICES FOR MEDICALLY UNDER-**  
4 **SERVED INDIVIDUALS.**

5 “(a) ESTABLISHMENT OF HEALTH SERVICES AC-  
6 CESS PROGRAM.—From amounts appropriated under this  
7 section, the Secretary shall, acting through the Bureau of  
8 Health Care Delivery Assistance, award grants under this  
9 section to federally qualified health centers (hereinafter re-  
10 ferred to in this section as ‘FQHC’s’) and other entities  
11 and organizations submitting applications under this sec-  
12 tion (as described in subsection (c)) for the purpose of  
13 providing access to services for medically underserved pop-  
14 ulations (as defined in section 330(b)(3)) or in high im-  
15 pact areas (as defined in section 329(a)(5)) not currently  
16 being served by a FQHC.

17 “(b) ELIGIBILITY FOR GRANTS.—

18 “(1) IN GENERAL.—The Secretary shall award  
19 grants under this section to entities or organizations  
20 described in this paragraph and paragraph (2) which  
21 have submitted a proposal to the Secretary to ex-  
22 pand such entities or organizations operations (in-  
23 cluding expansions to new sites (as determined nec-  
24 essary by the Secretary)) to serve medically under-



1 served populations or high impact areas not cur-  
2 rently served by a FQHC and which—

3 “(A) have as of January 1, 1991, been cer-  
4 tified by the Secretary as a FQHC under sec-  
5 tion 1905(l)(2)(B) of the Social Security Act;  
6 or

7 “(B) have submitted applications to the  
8 Secretary to qualify as FQHC’s under such sec-  
9 tion 1905(l)(2)(B); or

10 “(C) have submitted a plan to the Sec-  
11 retary which provides that the entity will meet  
12 the requirements to qualify as a FQHC when  
13 operational.

14 “(2) NON FQHC ENTITIES.—

15 “(A) ELIGIBILITY.—The Secretary shall  
16 also make grants under this section to public or  
17 private nonprofit agencies, health care entities  
18 or organizations which meet the requirements  
19 necessary to qualify as a FQHC except, the re-  
20 quirement that such entity have a consumer  
21 majority governing board and which have sub-  
22 mitted a proposal to the Secretary to provide  
23 those services provided by a FQHC as defined  
24 in section 1905(l)(2)(B) of the Social Security  
25 Act and which are designed to promote access

1 to primary care services or to reduce reliance on  
2 hospital emergency rooms or other high cost  
3 providers of primary health care services, pro-  
4 vided such proposal is developed by the entity  
5 or organizations (or such entities or organiza-  
6 tions acting in a consortium in a community)  
7 with the review and approval of the Governor of  
8 the State in which such entity or organization  
9 is located.

10 “(B) LIMITATION.—The Secretary shall  
11 provide in making grants to entities or organi-  
12 zations described in this paragraph that no  
13 more than 10 percent of the funds provided for  
14 grants under this section shall be made avail-  
15 able for grants to such entities or organizations.

16 “(c) APPLICATION REQUIREMENTS.—

17 “(1) IN GENERAL.—In order to be eligible to  
18 receive a grant under this section, a FQHC or other  
19 entity or organization must submit an application in  
20 such form and at such time as the Secretary shall  
21 prescribe and which meets the requirements of this  
22 subsection.

23 “(2) REQUIREMENTS.—An application submit-  
24 ted under this section must provide—

1           “(A)(i) for a schedule of fees or payments  
2           for the provision of the services provided by the  
3           entity designed to cover its reasonable costs of  
4           operations; and

5           “(ii) for a corresponding schedule of dis-  
6           counts to be applied to such fees or payments,  
7           based upon the patient’s ability to pay (deter-  
8           mined by using a sliding scale formula based on  
9           the income of the patient);

10          “(B) assurances that the entity or organi-  
11          zation provides services to persons who are eli-  
12          gible for benefits under title XVIII of the Social  
13          Security Act, for medical assistance under title  
14          XIX of such Act or for assistance for medical  
15          expenses under any other public assistance pro-  
16          gram or private health insurance program; and

17          “(C) assurances that the entity or organi-  
18          zation has made and will continue to make  
19          every reasonable effort to collect reimbursement  
20          for services—

21                 “(i) from persons eligible for assist-  
22                 ance under any of the programs described  
23                 in subparagraph (B); and

24                 “(ii) from patients not entitled to ben-  
25                 efits under any such programs.

1 “(d) LIMITATIONS ON USE OF FUNDS.—

2 “(1) IN GENERAL.—From the amounts award-  
3 ed to an entity or organization under this section,  
4 funds may be used for purposes of planning but may  
5 only be expended for the costs of—

6 “(A) assessing the needs of the populations  
7 or proposed areas to be served;

8 “(B) preparing a description of how the  
9 needs identified will be met; and

10 “(C) development of an implementation  
11 plan that addresses—

12 “(i) recruitment and training of per-  
13 sonnel; and

14 “(ii) activities necessary to achieve  
15 operational status in order to meet FQHC  
16 requirements under 1905(l)(2)(B) of the  
17 Social Security Act.

18 “(2) RECRUITING, TRAINING AND COMPENSA-  
19 TION OF STAFF.—From the amounts awarded to an  
20 entity or organization under this section, funds may  
21 be used for the purposes of paying for the costs of  
22 recruiting, training and compensating staff (clinical  
23 and associated administrative personnel (to the ex-  
24 tent such costs are not already reimbursed under  
25 title XIX of the Social Security Act or any other

1 State or Federal program)) to the extent necessary  
2 to allow the entity to operate at new or expended ex-  
3 isting sites.

4 “(3) FACILITIES AND EQUIPMENT.—From the  
5 amounts awarded to an entity or organization under  
6 this section, funds may be expended for the purposes  
7 of acquiring facilities and equipment but only for the  
8 cost of—

9 “(A) construction of new buildings (to the  
10 extent that new construction is found to be the  
11 most cost-efficient approach by the Secretary);

12 “(B) acquiring, expanding, and moderniz-  
13 ing of existing facilities;

14 “(C) purchasing essential (as determined  
15 by the Secretary) equipment; and

16 “(D) amortization of principal and pay-  
17 ment of interest on loans obtained for purposes  
18 of site construction, acquisition, modernization,  
19 or expansion, as well as necessary equipment.

20 “(4) SERVICES.—From the amounts awarded  
21 to an entity or organization under this section, funds  
22 may be expended for the payment of services but  
23 only for the costs of—

24 “(A) providing or arranging for the provi-  
25 sion of all services through the entity necessary

1 to qualify such entity as a FQHC under section  
2 1905(l)(2)(B) of the Social Security Act;

3 “(B) providing or arranging for any other  
4 service that a FQHC may provide and be reim-  
5 bursed for under title XIX of such Act; and

6 “(C) providing any unreimbursed costs of  
7 providing services as described in section 330(a)  
8 to patients.

9 “(e) PRIORITIES IN THE AWARDING OF GRANTS.—

10 “(1) CERTIFIED FQHC’s.—The Secretary shall  
11 give priority in awarding grants under this section  
12 to entities which have, as of January 1, 1991, been  
13 certified as a FQHC under section 1905(l)(2)(B) of  
14 the Social Security Act and which have submitted a  
15 proposal to the Secretary to expand their operations  
16 (including expansion to new sites) to serve medically  
17 underserved populations for high impact areas not  
18 currently served by a FQHC. The Secretary shall  
19 give first priority in awarding grants under this sec-  
20 tion to those FQHCs or other entities which propose  
21 to serve populations with the highest degree of  
22 unmet need, and which can demonstrate the ability  
23 to expand their operations in the most efficient man-  
24 ner.

1           “(2) QUALIFIED FQHC’S.—The Secretary shall  
2       give second priority in awarding grants to entities  
3       which have submitted applications to the Secretary  
4       which demonstrate that the entity will qualify as a  
5       FQHC under section 1905(l)(2)(B) of the Social Se-  
6       curity Act before it provides or arranges for the pro-  
7       vision of services supported by funds awarded under  
8       this section, and which are serving or proposing to  
9       serve medically underserved populations or high im-  
10      pact areas which are not currently served (or pro-  
11      posed to be served) by a FQHC.

12           “(3) EXPANDED SERVICES AND PROJECTS.—  
13      The Secretary shall give third priority in awarding  
14      grants in subsequent years to those FQHCs or other  
15      entities which have provided for expanded services  
16      and project and are able to demonstrate that such  
17      entity will incur significant unreimbursed costs in  
18      providing such expanded services.

19           “(f) RETURN OF FUNDS TO SECRETARY FOR COSTS  
20      REIMBURSED FROM OTHER SOURCES.—To the extent  
21      that an entity or organization receiving funds under this  
22      section is reimbursed from another source for the provi-  
23      sion of services to an individual, and does not use such  
24      increased reimbursement to expand services furnished,  
25      areas served, to compensate for costs of unreimbursed

1 services provided to patients, or to promote recruitment,  
2 training, or retention of personnel, such excess revenues  
3 shall be returned to the Secretary.

4 “(g) TERMINATION OF GRANTS.—

5 “(1) FAILURE TO MEET FQHC REQUIRE-  
6 MENTS.—

7 “(A) IN GENERAL.—With respect to any  
8 entity that is receiving funds awarded under  
9 this section and which subsequently fails to  
10 meet the requirements to qualify as a FQHC  
11 under section 1905(l)(2)(B) or is an entity that  
12 is not required to meet the requirements to  
13 qualify as a FQHC under section 1905(l)(2)(B)  
14 of the Social Security Act but fails to meet the  
15 requirements of this section, the Secretary shall  
16 terminate the award of funds under this section  
17 to such entity.

18 “(B) NOTICE.—Prior to any termination  
19 of funds under this section to an entity, the en-  
20 tities shall be entitled to 60 days prior notice of  
21 termination and, as provided by the Secretary  
22 in regulations, an opportunity to correct any de-  
23 ficiencies in order to allow the entity to con-  
24 tinue to receive funds under this section.



1           “(2) REQUIREMENTS.—Upon any termination  
2           of funding under this section, the Secretary may (to  
3           the extent practicable)—

4                   “(A) sell any property (including equip-  
5                   ment) acquired or constructed by the entity  
6                   using funds made available under this section  
7                   or transfer such property to another FQHC,  
8                   provided, that the Secretary shall reimburse  
9                   any costs which were incurred by the entity in  
10                  acquiring or constructing such property (includ-  
11                  ing equipment) which were not supported by  
12                  grants under this section; and

13                   “(B) recoup any funds provided to an en-  
14                  tity terminated under this section.

15           “(h) AUTHORIZATION OF APPROPRIATIONS.—There  
16           are authorized to be appropriated to carry out this section,  
17           \$100,000,000 for each of the fiscal years 1996 through  
18           1999.”.

19           (b) EFFECTIVE DATE.—The amendment made by  
20           subsection (a) shall become effective with respect to serv-  
21           ices furnished by a federally qualified health center or  
22           other qualifying entity described in this section beginning  
23           on or after October 1, 1995.

1 **SEC. 344. ACCUMULATION OF RESERVES BY CERTAIN ENTI-**  
2 **TIES.**

3 Any organization referred to in section 329, 330, or  
4 340 of the Public Health Service Act may accumulate re-  
5 serves.

6 **SEC. 345. MATERNAL AND INFANT CARE COORDINATION.**

7 (a) PURPOSE.—It is the purpose of this section to  
8 assist States in the development and implementation of  
9 coordinated, multidisciplinary, and comprehensive primary  
10 health care and social services, and health and nutrition  
11 education programs, designed to improve maternal and  
12 child health.

13 (b) GRANTS FOR IMPLEMENTATION OF PROGRAMS.—

14 (1) AUTHORITY.—The Secretary of Health and  
15 Human Services (hereafter referred to in this section  
16 as the “Secretary”) is authorized to award grants to  
17 States to enable such States to plan and implement  
18 coordinated, multidisciplinary, and comprehensive  
19 primary health care and social service programs tar-  
20 geted to pregnant women and infants.

21 (2) ELIGIBILITY.—To be eligible to receive a  
22 grant under this section, a State shall—

23 (A) prepare and submit to the Secretary  
24 an application at such time, in such manner,  
25 and containing such information as the Sec-  
26 retary may require;

1 (B) as part of the State application, pro-  
2 vide assurances that under the program estab-  
3 lished with amounts received under a grant, in-  
4 dividuals will have access to a broad range of  
5 primary health care services, social services,  
6 and health and nutrition programs designed to  
7 improve maternal and child health and a de-  
8 scription of how coordination of such services  
9 will improve maternal and child health based  
10 upon the goals of “Healthy People 2000: Na-  
11 tional Health Promotion and Disease Preven-  
12 tion Objectives”;

13 (C) as part of the State application, sub-  
14 mit a plan for the coordination of existing and  
15 proposed Federal and State resources, as ap-  
16 propriate, including amounts provided under  
17 the medicaid program under title XIX of the  
18 Social Security Act, the special supplemental  
19 food program under section 17 of the Child Nu-  
20 trition Act of 1966, family planning programs,  
21 substance abuse programs, State maternal and  
22 child health programs funded under title V of  
23 the Social Security Act, community and mi-  
24 grant health center programs under the Public

1 Health Service Act, and other publicly, or where  
2 practicable, privately supported programs;

3 (D) demonstrate that the major service  
4 providers to be involved, including private non-  
5 profit entities committed to improving maternal  
6 and infant health, are committed to and in-  
7 volved in the program to be funded with  
8 amounts received under the grant;

9 (E) with respect to States with high infant  
10 mortality rates among minority populations,  
11 demonstrate the involvement of major health,  
12 multiservice, professional, or civic group rep-  
13 resentatives of such minority groups in the  
14 planning and implementation of the State pro-  
15 gram; and

16 (F) demonstrate that activities under the  
17 State program are targeted to women of child-  
18 bearing age, particularly those at risk for hav-  
19 ing low birth weight babies.

20 (3) TERM OF GRANT.—A grant awarded under  
21 this subsection shall be for a period of 5 years.

22 (4) USE OF AMOUNTS.—Amounts received by a  
23 State under a grant awarded under this subsection  
24 shall be used to establish a State program to provide  
25 coordinated, multidisciplinary, and comprehensive

1 primary health care and social services, and health  
2 and nutrition education program services, that are  
3 designed to improve maternal and child health. Such  
4 amounts shall not be used for the construction of  
5 buildings or the purchase of medical equipment.

6 (5) MAINTENANCE OF EFFORT.—Any funds re-  
7 ceived by a State under this subsection shall supple-  
8 ment, and shall not supplant, funds that are ex-  
9 pended for similar purposes by the State.

10 (6) AUTHORIZATION OF APPROPRIATIONS.—  
11 There are authorized to be appropriated such sums  
12 as may be necessary to carry out the purposes of  
13 this subsection for fiscal years 1995 through 1998.

14 **SEC. 346. PRE-SCHOOL AND ELEMENTARY SCHOOL HEALTH**  
15 **EDUCATION PROGRAMS.**

16 Section 4605 of the Elementary and Secondary Edu-  
17 cation Act of 1965 (20 U.S.C. 3155) is amended to read  
18 as follows:

19 **“SEC. 4605. PRE-SCHOOL AND ELEMENTARY SCHOOL**  
20 **HEALTH EDUCATION PROGRAMS.**

21 “(a) PURPOSE.—It is the purpose of this section to  
22 establish a comprehensive school health education and pre-  
23 vention program for pre-school and elementary school stu-  
24 dents.

1       “(b) PROGRAM AUTHORIZED.—The Secretary shall  
2       award grants to States to enable such States to—

3               “(1) award grants to local or intermediate edu-  
4       cational agencies, and consortia thereof, to enable  
5       such agencies or consortia to establish, operate and  
6       improve local programs of comprehensive health edu-  
7       cation and prevention, early health intervention, and  
8       health education, in pre-school and elementary  
9       schools; and

10              “(2) develop training, technical assistance and  
11       coordination activities for the programs assisted pur-  
12       suant to paragraph (1).

13       “(c) USE OF FUNDS.—Grant funds under this sec-  
14       tion may be used to improve pre-school and elementary  
15       school education in the areas of—

16              “(1) personal health and fitness;

17              “(2) prevention of chronic diseases;

18              “(3) prevention and control of communicable  
19       diseases;

20              “(4) nutrition;

21              “(5) substance use and abuse;

22              “(6) accident prevention and safety;

23              “(7) community and environmental health;

24              “(8) mental and emotional health; and

1           “(9) the effective use of the health services de-  
2       livery system.

3           “(d) AUTHORIZATION OF APPROPRIATIONS.—

4           “(1) IN GENERAL.—There are authorized to be  
5       appropriated such sums as may be necessary to  
6       carry out the purposes of this section for fiscal years  
7       1996 through 2000.

8           “(2) AVAILABILITY.—Funds appropriated pur-  
9       suant to the authority of paragraph (1) in any fiscal  
10      year shall remain available for obligation and ex-  
11      penditure until the end of the fiscal year succeeding  
12      the fiscal year for which such funds were appro-  
13      priated.”.

14   **SEC. 347. FRONTIER STATES.**

15       (a) IN GENERAL.—Frontier States (including Alaska,  
16      Wyoming and Montana) may implement proposals to offer  
17      preventive services, including mobile preventive health cen-  
18      ters which may include centers equipped with various pre-  
19      ventive health services, such as mammography, eye care,  
20      X-ray, and other advanced equipment, and which may be  
21      located on aircraft, watercraft, or other forms of transpor-  
22      tation.

23       (b) DEMONSTRATION PROJECTS.—Frontier States  
24      may participate in demonstration projects under this or  
25      any other Act to improve recruitment, retention, and

1 training of rural providers, including nurse practitioners  
 2 and physician assistants. Such demonstration projects  
 3 shall give special consideration to the diverse needs of  
 4 Frontier States, and shall involve cooperative agreements  
 5 with a range of service delivery systems and teaching hos-  
 6 pitals.

7 **SEC. 348. INCREASE IN NATIONAL HEALTH SERVICE CORPS**  
 8 **AND AREA HEALTH EDUCATION CENTER**  
 9 **FUNDING.**

10 (a) NATIONAL HEALTH SERVICE CORPS.—Section  
 11 338H(b)(1) of the Public Health Service Act (42 U.S.C.  
 12 254q(b)(1)) is amended—

13 (1) by striking “1991, and” and inserting  
 14 “1991,”; and

15 (2) by striking “through 2000” and inserting “,  
 16 1993, and 1994, and \$20,000,000 for each of the  
 17 fiscal years 1995 through 2000”.

18 (b) AREA HEALTH EDUCATION CENTERS.—Section  
 19 746(i)(1) of such Act (42 U.S.C. 293j(i)(1)) is amended—

20 (1) in subparagraph (A), by striking “1995”  
 21 and inserting “1995, and \$20,000,000 for each of  
 22 the fiscal years 1996 through 2000”; and

23 (2) in subparagraph (C), by striking “and  
 24 1995” and inserting “1995, and \$20,000,000 for  
 25 each of the fiscal years 1996 through 2000”.



1 **SEC. 349. TELEMEDICINE FEDERAL INTERAGENCY TASK**  
2 **FORCE.**

3 (a) ESTABLISHMENT.—Not later than 90 days after  
4 the date of the enactment of this section, the Secretary  
5 of Health and Human Services shall establish a Federal  
6 interagency task force to be known as the ‘Interagency  
7 Task Force on Rural Telemedicine’ (hereafter in this sec-  
8 tion referred to as the “Task Force”).

9 (b) DUTIES.—

10 (1) IN GENERAL.—The Task Force shall—

11 (A) identify specific uses for telemedicine  
12 that have been proven to be effective to be used  
13 in the evaluation of applications for federally  
14 funded telemedicine demonstration projects, in-  
15 cluding any application submitted under this  
16 part;

17 (B) review and coordinate evaluations of  
18 all federally funded telemedicine and tele-  
19 communications infrastructure demonstration  
20 projects, including any demonstration project  
21 established under this subtitle;

22 (C) establish mechanisms to facilitate a  
23 local area needs assessment and consortium de-  
24 velopment process to assist entities conducting  
25 federally funded telemedicine demonstration

1 projects, including demonstration projects  
2 under this part; and

3 (D) review the provision of telemedicine  
4 services under the demonstration projects estab-  
5 lished under section 350.

6 (2) PUBLICATION OF RESULTS.—Not later than  
7 2 years after the Task Force is established, and an-  
8 nually thereafter, the Task Force shall analyze and  
9 publish a report of its findings under subparagraphs  
10 (A) through (D) of paragraph (1) and shall make  
11 such publications available to the Congress and the  
12 general public.

13 (c) MEMBERSHIP.—

14 (1) IN GENERAL.—The Task Force shall con-  
15 sist of representatives of—

16 (A) the Department of Health and Human  
17 Services;

18 (B) the Rural Electrification Administra-  
19 tion;

20 (C) the National Telecommunications In-  
21 formation Agency;

22 (D) the National Institutes of Health; and

23 (E) other agencies and departments that  
24 have responsibility for overseeing telemedicine  
25 projects.

1           (2) CHAIRPERSON.—A representative of the De-  
2       partment of Health and Human Services shall serve  
3       as the chairperson of the Task Force.

4       (d) BASIC PAY.—Each member of the Task Force  
5       shall serve without pay.

6       (e) MEETINGS.—The Task Force shall meet at the  
7       call of the chairperson.

8       (f) QUORUM.—A majority of the members shall con-  
9       stitute a quorum for the transaction of business.

10 **SEC. 350. DEMONSTRATION PROJECTS TO PROMOTE**  
11 **TELEMEDICINE.**

12       (a) DEFINITIONS.—For purposes of this section:

13           (1) RURAL HEALTH CARE PROVIDER.—The  
14       term “rural health care provider” means any public  
15       or private health care provider located in a rural  
16       area.

17           (2) NONHEALTH CARE ENTITY.—The term  
18       “nonhealth care entity” means any entity that is not  
19       involved in the provision of health care, including a  
20       business, educational institution, library, and prison.

21       (b) ESTABLISHMENT.—The Secretary, acting  
22       through the Office of Rural Health, shall award grants  
23       to eligible entities to establish demonstration projects  
24       under which an eligible entity establishes a rural-based

1 consortium that enables members of the consortium to uti-  
2 lize the telecommunications network—

3           (1) to strengthen the delivery of health care  
4 services in the rural area through the use of  
5 telemedicine;

6           (2) to provide for consultations involving trans-  
7 missions of detailed data about the patient that  
8 serves as a reasonable substitute for face-to-face  
9 interaction between the patient and consultant; and

10           (3) to make outside resources or business inter-  
11 action more available to the rural area.

12       (c) ELIGIBLE ENTITY.—To be eligible to receive a  
13 grant under this section an applicant entity shall propose  
14 a consortium that includes as members at least—

15           (1) one rural health care provider; and

16           (2) one nonhealth care entity located in the  
17 same rural area as the rural health care provider de-  
18 scribed in paragraph (1).

19 The Secretary may waive the membership requirement  
20 under paragraph (2) if the members described in para-  
21 graph (1) are unable to locate a nonhealth care entity lo-  
22 cated in the same rural area to participate in the dem-  
23 onstration project.

24       (d) APPLICATION.—To be eligible to receive a grant  
25 under this section, an eligible entity described in sub-

1 section (c) shall prepare and submit to the Secretary an  
2 application at such time, in such manner, and containing  
3 such information as the Secretary may require, including  
4 a description of the use to which the eligible entity would  
5 apply any amounts received under such grant, the source  
6 and amount of non-Federal funds the entity would pledge  
7 for the project, and a showing of the long-term sustain-  
8 ability of the project.

9 (e) GRANTS.—Grants under this section shall be dis-  
10 tributed in accordance with the following requirements:

11 (1) GRANT LIMIT.—The Secretary may not  
12 make a grant to an eligible entity under this section  
13 in excess of \$500,000 for each fiscal year in which  
14 an eligible entity conducts a project under this sec-  
15 tion.

16 (2) MATCHING FUNDS.—

17 (A) IN GENERAL.—The Secretary may not  
18 make a grant to an eligible entity under this  
19 section unless the eligible entity agrees to pro-  
20 vide non-Federal funds in an amount equal to  
21 not less than 20 percent of the total amount to  
22 be expended by the eligible entity in any fiscal  
23 year for the purpose of conducting the project  
24 under this section.

1 (B) ADJUSTMENTS.—The Secretary shall  
2 make necessary adjustments to the amount that  
3 an eligible entity may receive in a subsequent  
4 fiscal year if the eligible entity does not meet  
5 the requirements of subparagraph (A) in the  
6 preceding fiscal year.

7 (f) USE OF GRANT AMOUNTS.—

8 (1) IN GENERAL.—Amounts received under a  
9 grant awarded under this section shall be utilized for  
10 the development and operation of telemedicine sys-  
11 tems that serve rural areas. All such grant funds  
12 must be used to further the provision of health serv-  
13 ices to rural areas.

14 (2) RULES OF USE.—

15 (A) PERMISSIBLE USAGES.—Grant funds  
16 awarded under this section—

17 (i) shall primarily be used to support  
18 the costs of establishing and operating a  
19 telemedicine system that provides specialty  
20 consultations to rural communities;

21 (ii) may be used to demonstrate the  
22 application of telemedicine for preceptor-  
23 ship of medical students, residents, and  
24 other health professions students in rural  
25 training sites;

1 (iii) may be used for transmission  
2 costs, salaries, maintenance of equipment,  
3 and compensation of specialists and refer-  
4 ring practitioners;

5 (iv) may be used to pay the fees of  
6 consultants, but only to the extent that the  
7 total of such fees do not exceed 5 percent  
8 of the amount of the grant;

9 (v) may be used to demonstrate the  
10 use of telemedicine to facilitate collabora-  
11 tion between non-physician primary care  
12 practitioners (including physician assist-  
13 ants, nurse practitioners, certified nurse-  
14 midwives, and clinical nurse specialists)  
15 and physicians; and

16 (vi) may be used to test reimburse-  
17 ment methodologies under the medicare  
18 program under title XVIII of the Social  
19 Security Act and the medicaid program  
20 under title XIX of such Act for practition-  
21 ers participating in telemedicine activities.

22 (B) PROHIBITED USE OF FUNDS.—Grant  
23 funds shall not be used by members of a rural-  
24 based consortium for any of the following:

1 (i) Expenditures to purchase or lease  
2 equipment.

3 (ii) In the case of a member of a con-  
4 sortium that is an isolated rural facility,  
5 purchase of high-cost telecommunications  
6 technologies for the furnishing of  
7 telemedicine services that—

8 (I) incur high cost per minute of  
9 usage charges; or

10 (II) require consultants to be  
11 available at the same time as the pa-  
12 tient and the referring physician.

13 (iii) Purchase or installation of trans-  
14 mission equipment or establishment or op-  
15 eration of a telecommunications common  
16 carrier network.

17 (iv) Expenditures for indirect costs  
18 (as determined by the Secretary) to the ex-  
19 tent the expenditures would exceed more  
20 than 20 percent of the total grant funds.

21 (v) Construction (except for minor  
22 renovations related to the installation of  
23 equipment), or the acquisition or building  
24 of real property.



1 (g) MAINTENANCE OF EFFORT.—Any funds available  
 2 for the activities covered by a demonstration project con-  
 3 ducted under this section shall supplement, and shall not  
 4 supplant, funds that are expended for similar purposes  
 5 under any State, regional, or local program.

6 (h) EVALUATIONS.—Each eligible entity that con-  
 7 ducts a demonstration project under this section shall sub-  
 8 mit to the Secretary such information and interim evalua-  
 9 tions as the Secretary may require. The Secretary shall  
 10 provide the Interagency Task Force on Rural  
 11 Telemedicine with such evaluations and information sub-  
 12 mitted under the previous sentence as the Task Force may  
 13 required to carry out its duties under section 345(b).

14 (i) AUTHORIZATION OF APPROPRIATIONS.—There  
 15 are authorized to be appropriated to carry out this section,  
 16 \$10,000,000 for each of the fiscal years 1995 through  
 17 1997.

## 18 **Subtitle E—Payment Flexibility**

### 19 **SEC. 351. ESSENTIAL ACCESS COMMUNITY HOSPITAL** 20 **(EACH) AMENDMENTS.**

21 (a) UNLIMITED PARTICIPATING STATES; ELIMI-  
 22 NATION OF GRANT TIE-IN.—

23 (1) IN GENERAL.—Section 1820(a) of the So-  
 24 cial Security Act (42 U.S.C. 1395i-4(a)) is amended  
 25 to read as follows:

1 “(a) IN GENERAL.—

2 “(1) PROGRAM DESCRIBED.—There is hereby  
3 established a program under which the Secretary—

4 “(A) shall permit States that have submit-  
5 ted an application in accordance with subsection  
6 (b) to carry out the activities described in sub-  
7 sections (e) and (f); and

8 “(B) shall designate (under subsection (i))  
9 hospitals and facilities located in States partici-  
10 pating in a program under this section as es-  
11 sential access community hospitals or rural pri-  
12 mary care hospitals.

13 “(2) AVAILABILITY OF GRANTS.—

14 “(A) STATES.—The Secretary shall make  
15 grants available to selected States described in  
16 paragraph (1)(A) to carry out the activities de-  
17 scribed in subsection (d)(1).

18 “(B) ELIGIBLE HOSPITALS AND FACILI-  
19 TIES.—The Secretary shall make grants avail-  
20 able to selected eligible hospitals and facilities  
21 (or consortia of hospitals and facilities) to carry  
22 out the activities described in subsection  
23 (d)(2).’.

24 (2) CONFORMING AMENDMENTS.—

1           (A) Section 1820(b) of such Act (42  
2           U.S.C. 1395i-4(b)) is amended by striking  
3           “ELIGIBILITY OF STATES FOR GRANTS.—”  
4           through “subsection (a)(1)” and inserting “AP-  
5           PLICATION.—A State is eligible to participate in  
6           the program described in this section”.

7           (B) Section 1820(c) of such Act (42  
8           U.S.C. 1395i-4(c)) is amended—

9                   (i) in paragraph (1)—

10                       (I) in the matter preceding sub-  
11                       paragraph (A), by striking “(a)(2)”  
12                       and inserting “(a)(2)(B)”, and

13                       (II) in subparagraph (A), by  
14                       striking “receiving a grant under sub-  
15                       section (a)(1)” and inserting “partici-  
16                       pating in the program under this sec-  
17                       tion”; and

18                   (ii) in paragraph (3)—

19                       (I) by striking “STATE RECEIV-  
20                       ING GRANT.—” and inserting “STATE  
21                       PARTICIPATING IN THE PROGRAM.—”,  
22                       and

23                       (II) by striking “(a)(2)” and in-  
24                       serting “(a)(2)(B)”.

(C) Section 1820(d) of such Act (42 U.S.C. 1395i-4(d)) is amended—

(i) in paragraph (1), by striking “(a)(1)” and inserting “(a)(2)(A)”; and

(ii) in paragraph (2), by striking “(a)(2)” each place it appears and inserting “(a)(2)(B)”.

(C) Section 1820(i) of such Act (42 U.S.C. 1395i-4(i)) is amended—

(i) in paragraph (1)(A)(i), by striking “receiving a grant under subsection (a)(1)” and inserting “participating in the program under this section”; and

(ii) in paragraph (2)(A)(i), by striking “receiving a grant under subsection (a)(1)” and inserting “participating in the program under this section”.

(b) TREATMENT OF INPATIENT HOSPITAL SERVICES PROVIDED IN RURAL PRIMARY CARE HOSPITALS.—

(1) IN GENERAL.—Section 1820(f)(1)(F) of the Social Security Act (42 U.S.C. 1395i-4(f)(1)(F)) is amended to read as follows:

“(F) subject to paragraph (4), provides not more than 6 inpatient beds (meeting such conditions as the Secretary may establish) for pro-

1           viding inpatient care to patients requiring sta-  
2           bilization before discharge or transfer to a hos-  
3           pital, except that the facility may not provide  
4           any inpatient hospital services consisting of sur-  
5           gery or any other service requiring the use of  
6           general anesthesia (other than surgical proce-  
7           dures specified by the Secretary under section  
8           1833(i)(1)(A)) unless the attending physician  
9           certifies that the risk associated with transfer-  
10          ring the patient to a hospital for such services  
11          outweighs the benefits of transferring the pa-  
12          tient to a hospital for such services.”.

13           (2) LIMITATION ON AVERAGE LENGTH OF  
14          STAY.—Section 1820(f) of such Act (42 U.S.C.  
15          1395i–4(f)) is amended by adding at the end the fol-  
16          lowing new paragraph:

17           “(4) LIMITATION ON AVERAGE LENGTH OF IN-  
18          PATIENT STAYS.—The Secretary may terminate a  
19          designation of a rural primary care hospital under  
20          paragraph (1) if the Secretary finds that the average  
21          length of stay for inpatients at the facility during  
22          the previous year in which the designation was in ef-  
23          fect exceeded 72 hours. In determining the compli-  
24          ance of a facility with the requirement of the pre-  
25          vious sentence, there shall not be taken into account

1 periods of stay of inpatients in excess of 72 hours  
2 to the extent such periods exceed 72 hours because  
3 transfer to a hospital is precluded because of inclem-  
4 ent weather or other emergency conditions.”.

5 (3) CONFORMING AMENDMENT.—Section  
6 1814(a)(8) of such Act (42 U.S.C. 1395f(a)(8)) is  
7 amended by striking “such services” and all that fol-  
8 lows and inserting “the individual may reasonably be  
9 expected to be discharged or transferred to a hos-  
10 pital within 72 hours after admission to the rural  
11 primary care hospital.”.

12 (4) GAO REPORTS.—Not later than 2 years  
13 after the date of the enactment of this Act, the  
14 Comptroller General shall submit reports to Con-  
15 gress on—

16 (A) the application of the requirement  
17 under section 1820(f) of the Social Security Act  
18 (as amended by this subsection) that rural pri-  
19 mary care hospitals maintain an average length  
20 of inpatient stay during a year that does not  
21 exceed 72 hours; and

22 (B) the extent to which such requirement  
23 has resulted in such hospitals providing inpa-  
24 tient care beyond their capabilities or have lim-

1           ited the ability of such hospitals to provide  
2           needed services.

3           (c) DESIGNATION OF HOSPITALS.—

4           (1) PERMITTING DESIGNATION OF HOSPITALS  
5           LOCATED IN URBAN AREAS.—

6           (A) IN GENERAL.—Section 1820 of the So-  
7           cial Security Act (42 U.S.C. 1395i-4) is  
8           amended—

9                   (i) by striking paragraph (1) of sub-  
10                  section (e) and redesignating paragraphs  
11                  (2) through (6) as paragraphs (1) through  
12                  (5);

13                  (ii) in subsection (e)(1)(A) (as redes-  
14                  ignated by subparagraph (A))—

15                   (I) by striking “is located” and  
16                   inserting “except in the case of a hos-  
17                   pital located in an urban area, is lo-  
18                   cated”,

19                   (II) by striking “, (ii)” and in-  
20                   serting “or (ii)”, and

21                   (III) by striking “or (iii)” and all  
22                   that follows through “section,”; and

23                   (iii) in subsection (i)(1)(B), by strik-  
24                   ing “paragraph (3)” and inserting “para-  
25                   graph (2)”.

1 (B) NO CHANGE IN MEDICARE PROSPEC-  
 2 TIVE PAYMENT.—Section 1886(d)(5)(D) of  
 3 such Act (42 U.S.C. 1395ww(d)(5)(D)) is  
 4 amended—

5 (i) in clause (iii)(III), by inserting “lo-  
 6 cated in a rural area and” after “that is”,  
 7 and

8 (ii) in clause (v), by inserting “located  
 9 in a rural area and” after “in the case of  
 10 a hospital”.

11 (2) PERMITTING HOSPITALS LOCATED IN AD-  
 12 JOINING STATES TO PARTICIPATE IN STATE PRO-  
 13 GRAM.—

14 (A) IN GENERAL.—Section 1820 of such  
 15 Act (42 U.S.C. 1395i-4) is amended—

16 (i) by redesignating subsection (k) as  
 17 subsection (l); and

18 (ii) by inserting after subsection (j)  
 19 the following new subsection:

20 “(k) ELIGIBILITY OF HOSPITALS NOT LOCATED IN  
 21 PARTICIPATING STATES.—Notwithstanding any other  
 22 provision of this section—

23 “(1) for purposes of including a hospital or fa-  
 24 cility as a member institution of a rural health net-  
 25 work, a State may designate a hospital or facility



1       that is not located in the State as an essential access  
2       community hospital or a rural primary care hospital  
3       if the hospital or facility is located in an adjoining  
4       State and is otherwise eligible for designation as  
5       such a hospital;

6           “(2) the Secretary may designate a hospital or  
7       facility that is not located in a State receiving a  
8       grant under subsection (a)(1) as an essential access  
9       community hospital or a rural primary care hospital  
10      if the hospital or facility is a member institution of  
11      a rural health network of a State receiving a grant  
12      under such subsection; and

13           “(3) a hospital or facility designated pursuant  
14      to this subsection shall be eligible to receive a grant  
15      under subsection (a)(2).”.

16           (B) CONFORMING AMENDMENTS.—(i) Sec-  
17      tion 1820(c)(1) of such Act (42 U.S.C. 1395i-  
18      4(c)(1)) is amended by striking “paragraph  
19      (3)” and inserting “paragraph (3) or subsection  
20      (k)”.

21           (ii) Paragraphs (1)(A) and (2)(A) of sec-  
22      tion 1820(i) of such Act (42 U.S.C. 1395i-4(i))  
23      are each amended—

1 (I) in clause (i), by striking “(a)(1)”  
2 and inserting “(a)(1) (except as provided  
3 in subsection (k))”, and

4 (II) in clause (ii), by striking “sub-  
5 paragraph (B)” and inserting “subpara-  
6 graph (B) or subsection (k)”.

7 (d) SKILLED NURSING SERVICES IN RURAL PRIMARY  
8 CARE HOSPITALS.—Section 1820(f)(3) of the Social Secu-  
9 rity Act (42 U.S.C. 1395i-4(f)(3)) is amended by striking  
10 “because the facility” and all that follows and inserting  
11 the following: “because, at the time the facility applies to  
12 the State for designation as a rural primary care hospital,  
13 there is in effect an agreement between the facility and  
14 the Secretary under section 1883 under which the facili-  
15 ty’s inpatient hospital facilities are used for the furnishing  
16 of extended care services, except that the number of beds  
17 used for the furnishing of such services may not exceed  
18 the total number of licensed inpatient beds at the time  
19 the facility applies to the State for such designation  
20 (minus the number of inpatient beds used for providing  
21 inpatient care pursuant to paragraph (1)(F)). For pur-  
22 poses of the previous sentence, the number of beds of the  
23 facility used for the furnishing of extended care services  
24 shall not include any beds of a unit of the facility that  
25 is licensed as a distinct-part skilled nursing facility at the

1 time the facility applies to the State for designation as  
2 a rural primary care hospital.”.

3 (e) DEADLINE FOR DEVELOPMENT OF PROSPECTIVE  
4 PAYMENT SYSTEM FOR INPATIENT RURAL PRIMARY  
5 CARE HOSPITAL SERVICES.—Section 1814(l)(2) of the  
6 Social Security Act (42 U.S.C. 1395f(l)(2)) is amended  
7 by striking “January 1, 1993” and inserting “January 1,  
8 1996”.

9 (f) PAYMENT FOR OUTPATIENT RURAL PRIMARY  
10 CARE HOSPITAL SERVICES.—

11 (1) IMPLEMENTATION OF PROSPECTIVE PAY-  
12 MENT SYSTEM.—Section 1834(g) of the Social Secu-  
13 rity Act (42 U.S.C. 1395m(g)) is amended—

14 (A) in paragraph (1), by striking “during  
15 a year before 1993” and inserting “during a  
16 year before the prospective payment system de-  
17 scribed in paragraph (2) is in effect”; and

18 (B) in paragraph (2), by striking “January  
19 1, 1993,” and inserting “January 1, 1996,”.

20 (2) NO USE OF CUSTOMARY CHARGE IN DETER-  
21 MINING PAYMENT.—Section 1834(g)(1) of such Act  
22 (42 U.S.C. 1395m(g)(1)) is amended by adding at  
23 the end the following new flush sentence:

1 “The amount of payment shall be determined under  
 2 either method without regard to the amount of the  
 3 customary or other charge.”.

4 (g) CLARIFICATION OF PHYSICIAN STAFFING RE-  
 5 QUIREMENT FOR RURAL PRIMARY CARE HOSPITALS.—  
 6 Section 1820(f)(1)(H) of the Social Security Act (42  
 7 U.S.C. 1395i-4(f)(1)(H)) is amended by striking the pe-  
 8 riod and inserting the following: “, except that in deter-  
 9 mining whether a facility meets the requirements of this  
 10 subparagraph, subparagraphs (E) and (F) of that para-  
 11 graph shall be applied as if any reference to a ‘physician’  
 12 is a reference to a physician as defined in section  
 13 1861(r)(1).”.

14 (h) TECHNICAL AMENDMENTS RELATING TO PART  
 15 A DEDUCTIBLE, COINSURANCE, AND SPELL OF ILL-  
 16 NESS.—(1) Section 1812(a)(1) of the Social Security Act  
 17 (42 U.S.C. 1395d(a)(1)) is amended—

18 (A) by striking “inpatient hospital services” the  
 19 first place it appears and inserting “inpatient hos-  
 20 pital services or inpatient rural primary care hos-  
 21 pital services”;

22 (B) by striking “inpatient hospital services” the  
 23 second place it appears and inserting “such serv-  
 24 ices”; and

1 (C) by striking “and inpatient rural primary  
2 care hospital services”.

3 (2) Sections 1813(a) and 1813(b)(3)(A) of such Act  
4 (42 U.S.C. 1395e(a), 1395e(b)(3)(A)) are each amended  
5 by striking “inpatient hospital services” each place it ap-  
6 pears and inserting “inpatient hospital services or inpa-  
7 tient rural primary care hospital services”.

8 (3) Section 1813(b)(3)(B) of such Act (42 U.S.C.  
9 1395e(b)(3)(B)) is amended by striking “inpatient hos-  
10 pital services” and inserting “inpatient hospital services,  
11 inpatient rural primary care hospital services”.

12 (4) Section 1861(a) of such Act (42 U.S.C. 1395x(a))  
13 is amended—

14 (A) in paragraph (1), by striking “inpatient  
15 hospital services” and inserting “inpatient hospital  
16 services, inpatient rural primary care hospital serv-  
17 ices”; and

18 (B) in paragraph (2), by striking “hospital”  
19 and inserting “hospital or rural primary care hos-  
20 pital”.

21 (i) AUTHORIZATION OF APPROPRIATIONS.—Section  
22 1820(e) of the Social Security Act (42 U.S.C. 1395i–4(e)),  
23 as redesignated by subsection (c)(2)(A), is amended—

1 (1) in the matter preceding paragraph (1), by  
2 striking “1990, 1991, and 1992” and inserting  
3 “1990 through 1998”;

4 (2) in paragraph (1), by striking  
5 “\$10,000,000” and “(a)(1)” and inserting  
6 “\$30,000,000” and “(a)(2)(A)”, respectively; and

7 (3) in paragraph (2), by striking  
8 “\$15,000,000” and “(a)(2)” and inserting  
9 “\$45,000,000” and “(a)(2)(B)”, respectively.

10 (j) NO LIMITATION ON NUMBER OF RURAL PRIMARY  
11 CARE HOSPITALS IN NON-EACH STATES.—Section  
12 1820(i)(2)(C) of the Social Security Act (42 U.S.C.  
13 1395i–4(i)(2)(C)) is amended—

14 (1) by striking “15”; and

15 (2) by striking “(f)(1), except that nothing”  
16 and inserting “(f)(1) and establishes a relationship  
17 with a full-service rural hospital that meets the re-  
18 quirements described in paragraph (1) through (6)  
19 of subsection (e), except that such hospital need not  
20 meet the 75 bed requirement described in paragraph  
21 (3) of such subsection. Nothing”.

22 (k) EFFECTIVE DATE.—The amendments made by  
23 this section shall take effect on the date of the enactment  
24 of this Act.

1 **SEC. 352. DEMONSTRATION PROJECTS TO IMPROVE AC-**  
2 **CESS IN RURAL AREAS.**

3 (a) IN GENERAL.—Part A of title XVIII of the Social  
4 Security Act (42 U.S.C. 1395 et seq.) is amended by add-  
5 ing at the end the following new section:

6 “DEMONSTRATION PROJECTS TO IMPROVE ACCESS IN  
7 RURAL AREAS

8 “SEC. 1821. (a) MEDICAL ASSISTANCE FACILITY  
9 DEMONSTRATION PROJECT.—

10 (1) ESTABLISHMENT.—The Secretary shall pro-  
11 vide for the establishment of demonstration projects  
12 in States providing that medical assistance facilities  
13 located in such States may receive payment in ac-  
14 cordance with paragraph (4).

15 “(2) APPLICATIONS.—

16 “(A) IN GENERAL.—Each State desiring to  
17 conduct a demonstrationproject under this sub-  
18 section shall prepare and submit to the Sec-  
19 retary an application, at such time, in such  
20 manner, and containing such information as the  
21 Secretary may require, including an explanation  
22 of a plan for evaluating the project.

23 “(B) APPROVAL OF APPLICATIONS.—A  
24 State that submits an application under sub-  
25 paragraph (A) may begin a demonstration  
26 project under this subsection—

1                   “(i) upon approval of such application  
2                   by the Secretary; or

3                   “(ii) at the end of the 60-day period  
4                   beginning on the date such application is  
5                   submitted, unless the Secretary denies the  
6                   application during such period.

7                   “(3) MEDICAL ASSISTANCE FACILITY.—The  
8                   term ‘medical assistance facility’ means for a fiscal  
9                   year, a facility with respect to which the Secretary  
10                  finds the following:

11                  “(A) The facility is located in a county (or  
12                  equivalent unit of local government) with fewer  
13                  than 6 residents per square mile or is located  
14                  more than a 35 mile drive from a hospital, a  
15                  rural primary care hospital, or another facility  
16                  described in this subsection.

17                  “(B) The facility furnishes services to ill or  
18                  injured individuals prior to the transportation  
19                  of such individuals to a hospital or furnishes in-  
20                  patient care to individuals needing such care for  
21                  a period not longer than 96 hours.

22                  “(C) The facility permits a physician as-  
23                  sistant or nurse practitioner to admit and treat  
24                  patients under the supervision of a physician  
25                  not present in such facility.



1           “(D) The facility meets the requirements  
2 of section 1861(e) that are applicable to a hos-  
3 pital located in a rural area except that—

4               “(i) with respect to any requirements  
5 relating to the number of hours that the  
6 facility must be open on a daily or weekly  
7 basis, the facility is only required to meet  
8 the requirement to provide emergency care  
9 on a 24-hour basis;

10              “(ii) with respect to any services re-  
11 quired under such section to be furnished  
12 by a dietician, pharmacist, laboratory tech-  
13 nician, medical technologist, and radiologi-  
14 cal technologist, the facility may furnish  
15 such services on a part-time, off-site basis;  
16 and

17              “(iii) the inpatient care described in  
18 subparagraph (B) may be furnished by a  
19 physician assistant or nurse practitioner as  
20 provided in subparagraph (C).

21           “(E) The facility receives a certification of  
22 medical necessity and appropriateness by a peer  
23 review organization (or the equivalent of a peer  
24 review organization) upon admitting each pa-  
25 tient on an inpatient basis or, in the case of ad-

1 missions that do not occur during regular busi-  
2 ness hours, receives such a certification at the  
3 earliest possible time.

4 “(F) The facility may enter into an agree-  
5 ment with the Secretary under section 1883  
6 under which the facility’s inpatient hospital fa-  
7 cilities may be used for the furnishing of serv-  
8 ices of the type which, if furnished by a skilled  
9 nursing facility, would constitute extended care  
10 services.

11 “(4) PAYMENT FOR SERVICES.—Each medical  
12 assistance facility located in a State participating in  
13 a demonstration project under this subsection shall  
14 receive payment for inpatient medical assistance fa-  
15 cility services (as defined in section 1861(oo)(2)) in  
16 accordance with section 1814(m) and outpatient  
17 medical assistance facility services (as defined in sec-  
18 tion 1861(oo)(3)) in accordance with section  
19 1834(i).

20 “(5) GRANTS.—The Secretary shall award  
21 grants to—

22 “(A) selected States participating in a  
23 demonstration project under this subsection for  
24 the purpose of assisting such States in promot-

1           ing the establishment of medical assistance fa-  
2           cilities; and

3           “(B) selected facilities in States participat-  
4           ing in a demonstration project under this sec-  
5           tion for the purpose of financing the costs a fa-  
6           cility incurs in converting itself to a medical as-  
7           sistance facility.

8           “(6) MAINTENANCE OF EFFORT.—Any funds  
9           available for the activities covered by a demonstra-  
10          tion project conducted under this subsection shall  
11          supplement, and shall not supplant, funds that are  
12          expended for similar purposes under any State, re-  
13          gional, or local program.

14          “(7) DURATION.—A demonstration project  
15          under this subsection shall be conducted for a period  
16          not to exceed 8 years.

17          “(8) EVALUATIONS AND REPORTS.—

18                 “(A) EVALUATIONS.—Each State that con-  
19                 ducts a demonstration project under this sub-  
20                 section shall submit to the Secretary a final  
21                 evaluation of such project within 360 days of  
22                 the termination of such project and such in-  
23                 terim evaluations as the Secretary may require.

24                 “(B) REPORTS TO CONGRESS.—Not later  
25                 than 360 days after the first demonstration

project under this subsection begins, and annually thereafter for each year in which a project is conducted under this subsection, the Secretary shall submit a report to the appropriate committees of the Congress which evaluates the effectiveness of the demonstration projects conducted under this subsection and includes any legislative recommendations determined appropriate by the Secretary.

“(9) AUTHORIZATION OF APPROPRIATIONS.—

There are authorized to be appropriated for each of the fiscal years 1995 through 2000 from the Federal Hospital Insurance Trust Fund—

“(A) \$20,000,000 for grants to States under paragraph (5)(A); and

“(B) \$20,000,000 for grants to facilities under paragraph (5)(B).

“(b) RURAL EMERGENCY ACCESS CARE HOSPITAL DEMONSTRATION PROJECT.—

“(1) IN GENERAL.—

“(A) ESTABLISHMENT.—The Secretary shall provide for the establishment of demonstration projects in States providing that rural emergency access care hospitals located in such States may receive payment in accordance

1 with paragraph (5) for rural emergency access  
2 care hospital services provided to medicare  
3 beneficiaries.

4 “(2) APPLICATIONS.—

5 “(A) IN GENERAL.—Each State desiring to  
6 conduct a demonstration project under this sub-  
7 section shall prepare and submit to the Sec-  
8 retary an application, at such time, in such  
9 manner, and containing such information as the  
10 Secretary may require, including an explanation  
11 of a plan for evaluating the project.

12 “(B) APPROVAL OF APPLICATIONS.—A  
13 State that submits an application under sub-  
14 paragraph (A) may begin a demonstration  
15 project under this subsection—

16 “(i) upon approval of such application  
17 by the Secretary; or

18 “(ii) at the end of the 60-day period  
19 beginning on the date such application is  
20 submitted, unless the Secretary denies the  
21 application during such period.

22 “(3) RURAL EMERGENCY ACCESS CARE HOS-  
23 PITAL.—For purposes of this subsection, the term  
24 ‘rural emergency access care hospital’ means, for a

1       fiscal year, a facility with respect to which the Sec-  
2       retary finds the following:

3               “(A) The facility is located in a rural area  
4               (as defined in section 1886(d)(2)(D)).

5               “(B) The facility was a hospital under this  
6               title at any time during the 5-year period that  
7               ends on the date of the enactment of this sub-  
8               section.

9               “(C) The facility is in danger of closing  
10              due to low inpatient utilization rates and nega-  
11              tive operating losses, and the closure of the fa-  
12              cility would limit the access of individuals resid-  
13              ing in the facility’s service area to emergency  
14              services.

15              “(D) The facility has entered into (or  
16              plans to enter into) an agreement with a hos-  
17              pital with a participation agreement in effect  
18              under section 1866(a), and under such agree-  
19              ment the hospital shall accept patients trans-  
20              ferred to the hospital from the facility and re-  
21              ceive data from and transmit data to the facil-  
22              ity.

23              “(E) There is a practitioner who is quali-  
24              fied to provide advanced cardiac life support  
25              services (as determined by the State in which

1 the facility is located) on-site at the facility on  
2 a 24-hour basis.

3 “(F) A physician is available on-call to  
4 provide emergency medical services on a 24-  
5 hour basis.

6 “(G) The facility meets such staffing re-  
7 quirements as would apply under section  
8 1861(e) to a hospital located in a rural area,  
9 except that—

10 “(i) the facility need not meet hospital  
11 standards relating to the number of hours  
12 during a day, or days during a week, in  
13 which the facility must be open, except in-  
14 sofar as the facility is required to provide  
15 emergency care on a 24-hour basis under  
16 subparagraphs (E) and (F); and

17 “(ii) the facility may provide any serv-  
18 ices otherwise required to be provided by a  
19 full-time, on-site dietician, pharmacist, lab-  
20 oratory technician, medical technologist, or  
21 radiological technologist on a part-time,  
22 off-site basis.

23 “(H) The facility meets the requirements  
24 applicable to clinics and facilities under sub-  
25 paragraphs (C) through (J) of paragraph (2) of

1 section 1861(aa) and of clauses (ii) and (iv) of  
2 the second sentence of such paragraph (or, in  
3 the case of the requirements of subparagraph  
4 (E), (F), or (J) of such paragraph, would meet  
5 the requirements if any reference in such sub-  
6 paragraph to a ‘nurse practitioner’ or to ‘nurse  
7 practitioners’ was deemed to be a reference to  
8 a ‘nurse practitioner or nurse’ or to ‘nurse  
9 practitioners or nurses’), except that in deter-  
10 mining whether a facility meets the require-  
11 ments of this subparagraph, subparagraphs (E)  
12 and (F) of that paragraph shall be applied as  
13 if any reference to a ‘physician’ is a reference  
14 to a physician as defined in section 1861(r)(1).

15 “(4) RURAL EMERGENCY ACCESS CARE HOS-  
16 PITAL SERVICES.—For purposes of this subsection,  
17 the term ‘rural emergency access care hospital serv-  
18 ices’ means the following services provided by a rural  
19 emergency access care hospital:

20 “(A) An appropriate medical screening ex-  
21 amination (as described in section 1867(a)).

22 “(B) Necessary stabilizing examination  
23 and treatment services for an emergency medi-  
24 cal condition and labor (as described in section  
25 1867(b)).”.



1           “(5) PAYMENT FOR SERVICES.—Each rural  
2           emergency access care hospital located in a State  
3           participating in a demonstration project under this  
4           subsection shall receive payment for rural emergency  
5           access care hospital services in accordance with sec-  
6           tion 1833(a)(6).

7           “(6) GRANTS.—The Secretary shall award  
8           grants to—

9                   “(A) selected States participating in a  
10           demonstration project under this subsection for  
11           the purpose of assisting such States in promot-  
12           ing the establishment of rural emergency access  
13           care hospitals; and

14                   “(B) selected facilities in States participat-  
15           ing in a demonstration project under this sec-  
16           tion for the purpose of financing the costs a fa-  
17           cility incurs in converting itself to a rural emer-  
18           gency access care hospitals.

19           “(7) MAINTENANCE OF EFFORT.—Any funds  
20           available for the activities covered by a demonstra-  
21           tion project conducted under this subsection shall  
22           supplement, and shall not supplant, funds that are  
23           expended for similar purposes under any State, re-  
24           gional, or local program.

1           “(8) DURATION.—A demonstration project  
2           under this subsection shall be conducted for a period  
3           not to exceed 8 years.

4           “(9) EVALUATIONS AND REPORTS.—

5                 “(A) EVALUATIONS.—Each State that con-  
6                 ducts a demonstration project under this sub-  
7                 section shall submit to the Secretary a final  
8                 evaluation of such project within 360 days of  
9                 the termination of such project and such in-  
10                terim evaluations as the Secretary may require.

11               “(B) REPORTS TO CONGRESS.—Not later  
12               than 360 days after the first demonstration  
13               project under this subsection begins, and annu-  
14               ally thereafter for each year in which a project  
15               is conducted under this subsection, the Sec-  
16               retary shall submit a report to the appropriate  
17               committees of the Congress which evaluates the  
18               effectiveness of the demonstration projects con-  
19               ducted under this subsection and includes any  
20               legislative recommendations determined appro-  
21               priate by the Secretary.

22           “(10) AUTHORIZATION OF APPROPRIATIONS.—  
23           There are authorized to be appropriated for each of  
24           the fiscal years 1995 through 2000 from the Federal  
25           Hospital Insurance Trust Fund—

7 (1) AMENDMENTS TO PART A.—

12 “Medical Assistance Facility; Medical Assistance Facility  
13 Services

(2) The term ‘inpatient medical assistance facility services’ means items and services furnished to an inpatient of a medical assistance facility by such facility that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.”.

(B) COVERAGE AND PAYMENT.—(i) Section 1812(a)(1) of such Act (42 U.S.C. 1395d(a)(1)) is amended by striking “and inpatient rural primary care hospital services” and inserting “, inpatient rural primary care hospital services, and inpatient medical assistance facility services”.

(ii) Section 1814 of such Act (42 U.S.C. 1395f) is amended—

(I) in subsection (a)—

(aa) by striking “and” at the end of paragraph (7),

(bb) by striking the period at the end of paragraph (8) and inserting “; and”, and

(cc) by inserting after paragraph (8) the following new paragraph:

“(9) in the case of inpatient medical assistance facility services, a physician certifies that such services were required to be immediately furnished on a temporary, inpatient basis.”;

(ii) in subsection (b), by striking “inpatient rural primary care hospital services,” and inserting “inpatient rural primary care hospital services, other than a medical assistance facility

1 providing inpatient medical assistance facility  
 2 services,”; and

3 (III) by adding at the end the follow-  
 4 ing new subsection:

5 “Payment for Inpatient Medical Assistance Facility  
 6 Services

7 “(m) The amount of payment under this part for in-  
 8 patient medical assistance facility services is the reason-  
 9 able costs of the medical assistance facility in providing  
 10 such services.”.

11 (C) TREATMENT OF MEDICAL ASSISTANCE  
 12 FACILITIES AS PROVIDERS OF SERVICES.—(i)  
 13 Section 1861(u) of such Act (42 U.S.C.  
 14 1395x(u)) is amended by inserting “medical as-  
 15 sistance facility,” after “rural primary care hos-  
 16 pital,”.

17 (ii) The first sentence of section 1864(a) of  
 18 such Act (42 U.S.C. 1395aa(a)) is amended by  
 19 inserting “a medical assistance facility, as de-  
 20 fined in section 1861(oo)(1),” after  
 21 “1861(mm)(1),”.

22 (iii) The third sentence of section 1865(a)  
 23 of such Act (42 U.S.C. 1395bb(a)) is amended  
 24 by striking “or 1861(mm)(1)” and inserting  
 25 “1861(mm)(1), or 1861(oo)(1),”.

1 (D) CONFORMING AMENDMENTS.—(i) Sec-  
2 tion 1128A(b)(1) of such Act (42 U.S.C.  
3 1320a–7a(b)(1)) is amended—

4 (I) by striking “or a rural primary  
5 care hospital” the first place it appears  
6 and inserting “, a rural primary care hos-  
7 pital, or a medical assistance facility”; and

8 (II) by striking “or a rural primary  
9 care hospital” the second place it appears  
10 and inserting “, the rural primary care  
11 hospital, or the medical assistance facil-  
12 ity”.

13 (ii) Section 1128B(c) of such Act (42  
14 U.S.C. 1320a–7b(c)) is amended by inserting  
15 “medical assistance facility,” after “rural pri-  
16 mary care hospital,”.

17 (iii) Section 1134 of such Act (42 U.S.C.  
18 1320b–4) is amended by striking “or rural pri-  
19 mary care hospitals” each place it appears and  
20 inserting “, rural primary care hospitals, or  
21 medical assistance facilities”.

22 (iv) Section 1138(a)(1) of such Act (42  
23 U.S.C. 1320b–8(a)(1)) is amended—

24 (I) in the matter preceding subpara-  
25 graph (A), by striking “or rural primary

1           care hospital” and inserting “, rural pri-  
2           mary care hospital, or medical assistance  
3           facility”, and

4           (II) in the matter preceding clause (i)  
5           of subparagraph (A), by striking “or rural  
6           primary care hospital” and inserting “,  
7           rural primary care hospital, or medical as-  
8           sistance facility”.

9           (v) Section 1164(e) of such Act (42 U.S.C.  
10          1320c-13(e)) is amended by inserting “medical  
11          assistance facilities,” after “rural primary care  
12          hospitals,”.

13          (vi) Section 1816(c)(2)(C) of such Act (42  
14          U.S.C. 1395h(c)(2)(C)) is amended by inserting  
15          “medical assistance facility,” after “rural pri-  
16          mary care hospital,”.

17          (vii) Section 1833 of such Act (42 U.S.C.  
18          1395l) is amended—

19               (I) in subsection (h)(5)(A)(iii)—

20                   (aa) by striking “or rural pri-  
21                   mary care hospital” and inserting  
22                   “rural primary care hospital, or medi-  
23                   cal assistance facility”; and

1 (bb) by striking “to the hospital”  
2 and inserting “to the hospital or the  
3 facility”;

4 (II) in subsection (i)(1)(A), by insert-  
5 ing “medical assistance facility,” after  
6 “rural primary care hospital,”;

7 (III) in subsection (i)(3)(A), by strik-  
8 ing “or rural primary care hospital serv-  
9 ices” and inserting “rural primary care  
10 hospital services, or medical assistance fa-  
11 cility services”;

12 (IV) in subsection (l)(5)(A), by insert-  
13 ing “medical assistance facility,” after  
14 “rural primary care hospital,” each place it  
15 appears; and

16 (V) in subsection (l)(5)(C), by striking  
17 “or rural primary care hospital” each place  
18 it appears and inserting “, rural primary  
19 care hospital, or medical assistance facil-  
20 ity”.

21 (viii) Section 1835(c) of such Act (42  
22 U.S.C. 1395n(c)) is amended by adding at the  
23 end the following: “A medical assistance facility  
24 shall be considered a hospital for purposes of  
25 this subsection.”.



1 (ix) Section 1842(b)(6)(A)(ii) of such Act  
2 (42 U.S.C. 1395u(b)(6)(A)(ii)) is amended by  
3 inserting “medical assistance facility,” after  
4 “rural primary care hospital,”.

5 (x) Section 1861 of such Act (42 U.S.C.  
6 1395x) is amended—

7 (I) in the last sentence of subsection  
8 (e), by striking “1861(mm)(1))” and in-  
9 serting “1861(mm)(1)) or a medical assist-  
10 ance facility (as defined in section  
11 1861(oo)(1)).”,

12 (II) in subsection (w)(1) by inserting  
13 “medical assistance facility,” after “rural  
14 primary care hospital,”, and

15 (III) in subsection (w)(2), by striking  
16 “or rural primary care hospital” each place  
17 it appears and inserting “, rural primary  
18 care hospital, or medical assistance facil-  
19 ity”.

20 (xi) Section 1862(a)(14) of such Act (42  
21 U.S.C. 1395y(a)(14)) is amended by striking  
22 “or rural primary care hospital” each place it  
23 appears and inserting “, rural primary care  
24 hospital, or medical assistance facility”.

1           (xii) Section 1866(a)(1) of such Act (42  
2           U.S.C 1395cc(a)(1)) is amended—

3           (I) in subparagraph (F)(ii), by insert-  
4           ing “medical assistance facilities,” after  
5           “rural primary care hospitals,”;

6           (II) in subparagraph (H)—

7           (aa) in the matter preceding  
8           clause (i), by inserting “and in the  
9           case of medical assistance facilities  
10          which provide inpatient medical assist-  
11          ance facility services” after “rural pri-  
12          mary care hospital services”; and

13          (bb) in clauses (i) and (ii), by  
14          striking “hospital” each place it ap-  
15          pears and inserting “hospital or facil-  
16          ity”;

17          (III) in subparagraph (I)—

18          (aa) in the matter preceding  
19          clause (i), by striking “or rural pri-  
20          mary care hospital” and inserting “, a  
21          rural primary care hospital, or a med-  
22          ical assistance facility”; and

23          (bb) in clause (ii), by striking  
24          “the hospital” and inserting “the hos-  
25          pital or the facility”; and

1 (IV) in subparagraph (N)—

2 (aa) in the matter preceding  
3 clause (i), by striking “and rural pri-  
4 mary hospitals” and inserting “, rural  
5 primary care hospitals, and medical  
6 assistance facilities”;

7 (bb) in clause (i), by striking “or  
8 rural primary care hospital,” and in-  
9 serting “, rural primary care hospital,  
10 or medical assistance facility,”; and

11 (cc) in clause (ii), by striking  
12 “hospital” and inserting “hospital or  
13 facility”.

14 (xiii) Section 1866(a)(3) of such Act (42  
15 U.S.C 1395cc(a)(3)) is amended—

16 (I) by striking “rural primary care  
17 hospital,” each place it appears in sub-  
18 paragraphs (A) and (B) and inserting  
19 “rural primary care hospital, medical as-  
20 sistance facility,”, and

21 (II) in subparagraph (C)(ii)(II), by  
22 striking “rural primary care hospitals,”  
23 each place it appears and inserting “rural  
24 primary care hospitals, medical assistance  
25 facilities”.

1           (xiv) Section 1867(e)(5) of such Act (42  
 2           U.S.C. 1395dd(e)(5)) is amended by striking  
 3           “1861(mm)(1))” and inserting “1861(mm)(1))  
 4           or a medical assistance facility (as defined in  
 5           section 1861(oo)(1)).”.

6           (2) AMENDMENTS TO PART B.—

7           (A) COVERAGE.—(i) Section 1861(oo) of  
 8           the Social Security Act (42 U.S.C. 1395x(oo)),  
 9           as added by paragraph (1)(A), is amended by  
 10          adding at the end the following new paragraph:

11          “(3) The term ‘outpatient medical assistance facility  
 12          services’ means medical and other health services fur-  
 13          nished by a medical assistance facility on an outpatient  
 14          basis.”.

15          (ii) Section 1832(a)(2) of such Act (42  
 16          U.S.C. 1395k(a)(2)) is amended—

17               (I) in subparagraph (I), by striking  
 18               “and” at the end;

19               (II) in subparagraph (J), by striking  
 20               the period at the end and inserting “;  
 21               and”; and

22               (III) by adding at the end the follow-  
 23               ing new subparagraph:

24               “(K) outpatient medical assistance facility  
 25               services (as defined in section 1861(oo)(3)).”.

1 (B) PAYMENT.—(i) Section 1833(a) of  
2 such Act (42 U.S.C. 1395l(a)) is amended—

3 (I) in paragraph (2), in the matter  
4 preceding subparagraph (A), by striking  
5 “and (I)” and inserting “(I), and (K)”;

6 (II) in paragraph (6), by striking  
7 “and” at the end;

8 (III) in paragraph (7), by striking the  
9 period at the end and inserting “; and”;  
10 and

11 (IV) by adding at the end the follow-  
12 ing new paragraph:

13 “(8) in the case of outpatient medical assist-  
14 ance facility services, the amounts described in sec-  
15 tion 1834(i).”.

16 (ii) Section 1834 of such Act (42 U.S.C.  
17 1395m) is amended by adding at the end the  
18 following new subsection:

19 “(i) PAYMENT FOR OUTPATIENT MEDICAL ASSIST-  
20 ANCE FACILITY SERVICES.—The amount of payment for  
21 outpatient medical assistance facility services provided in  
22 a medical assistance facility under this part shall be deter-  
23 mined by one of the two following methods, as elected by  
24 the medical assistance facility:

1           “(1) COST-BASED FACILITY FEE PLUS PROFES-  
2       SIONAL CHARGES.—

3           “(A) FACILITY FEE.—With respect to fa-  
4       cility services, not including any services for  
5       which payment may be made under subpara-  
6       graph (B), there shall be paid amounts equal to  
7       the amounts described in section 1833(a)(2)(B)  
8       (describing amounts paid for hospital out-  
9       patient services).

10          “(B) REASONABLE CHARGES FOR PROFES-  
11       SIONAL SERVICES.—In electing treatment under  
12       this paragraph, payment for professional medi-  
13       cal services otherwise included within outpatient  
14       medical assistance facility services shall be  
15       made under such other provisions of this part  
16       as would apply to payment for such services if  
17       they were not included in outpatient medical as-  
18       sistance facility services.

19          “(2) ALL-INCLUSIVE RATE.—

20          “(A) IN GENERAL.—With respect to both  
21       facility services and professional medical serv-  
22       ices, there shall be paid amounts equal to the  
23       excess of—

24               “(i) the costs which are reasonable  
25               and related to the cost of furnishing such

1 services or which are based on such other  
2 tests of reasonableness as the Secretary  
3 may prescribe in regulations, over

4 “(ii) the amount the facility may  
5 charge as described in clause (i) of section  
6 1866(a)(2)(A).

7 “(B) LIMITATION.—

8 “(i) IN GENERAL.—The payment  
9 amount determined under subparagraph  
10 (A) with respect to items and services shall  
11 not exceed 80 percent of the amount deter-  
12 mined under clause (i) of such subpara-  
13 graph with respect to such items and serv-  
14 ices.

15 “(ii) CERTAIN ITEMS AND SERV-  
16 ICES.—Clause (i) shall not apply to—

17 “(I) items and services described  
18 in section 1861(s)(10)(A), and

19 “(II) items and services fur-  
20 nished in connection with obtaining a  
21 second opinion required under section  
22 1164(c)(2), or third opinion, if the  
23 second opinion was in disagreement  
24 with the first opinion.”.

1           (3) EFFECTIVE DATE.—The amendments made  
2       by this subsection shall be effective for services pro-  
3       vided on or after the October 1, 1995.

4       (c) RURAL EMERGENCY ACCESS CARE HOSPITALS.—

5           (1) RURAL EMERGENCY ACCESS CARE HOS-  
6       PITALS DESCRIBED.—Section 1861 of the Social Se-  
7       curity Act (42 U.S.C. 1395x) is amended by adding  
8       at the end the following new subsection:

9       “Rural Emergency Access Care Hospital; Rural  
10       Emergency Access Care Hospital Services  
11       “(pp)(1) The term ‘rural emergency access care hos-  
12       pital’ means, for a fiscal year, a facility in a State partici-  
13       pating in a demonstration project under section 1820(b)  
14       and that meets the criteria described in subparagraphs (A)  
15       through (H) of section 1820(b)(3).

16       “(2) The term ‘rural emergency access care hospital  
17       services’ means the following services provided by a rural  
18       emergency access care hospital:

19           “(A) An appropriate medical screening exam-  
20       ination (as described in section 1867(a)).

21           “(B) Necessary stabilizing examination and  
22       treatment services for an emergency medical condi-  
23       tion and labor (as described in section 1867(b)).”.

24       (2) REQUIRING RURAL EMERGENCY ACCESS  
25       CARE HOSPITALS TO MEET HOSPITAL ANTI-DUMPING



1        REQUIREMENTS.—Section 1867(e)(5) of such Act  
 2        (42 U.S.C. 1395(e)(5)) is amended by striking  
 3        “1861(mm)(1)” and inserting “1861(mm)(1)) and a  
 4        rural emergency access care hospital (as defined in  
 5        section 1861(pp)(1))”.

6            (3) COVERAGE OF AND PAYMENT FOR SERV-  
 7        ICES.—Section 1832(a)(2) of the Social Security Act  
 8        (42 U.S.C. 1395k(a)(2)), as amended in subsection  
 9        (b)(2)(A)(ii), is amended—

10            (A) by striking “and” at the end of sub-  
 11            paragraph (J);

12            (B) by striking the period at the end of  
 13            subparagraph (K) and inserting “; and”; and

14            (C) by adding at the end the following new  
 15            subparagraph:

16            “(L) rural emergency access care hospital  
 17            services (as defined in section 1861(pp)(2)).”

18            (4) PAYMENT BASED ON PAYMENT FOR OUT-  
 19        PATIENT RURAL PRIMARY CARE HOSPITAL SERV-  
 20        ICES.—

21            (A) IN GENERAL.—Section 1833(a)(6) of  
 22            the Social Security Act (42 U.S.C. 1395l(a)(6))  
 23            is amended by striking “services,” and inserting  
 24            “services and rural emergency access care hos-  
 25            pital services,”.

1 (B) PAYMENT METHODOLOGY DE-  
 2 SCRIBED.—Section 1834(g) of such Act (42  
 3 U.S.C. 1395m(g)) is amended—

4 (i) in the heading, by striking “SERV-  
 5 ICES” and inserting “SERVICES AND  
 6 RURAL EMERGENCY ACCESS CARE HOS-  
 7 PITAL SERVICES”; and

8 (ii) by adding at the end the following  
 9 new paragraph:

10 “(3) APPLICATION OF METHODS TO PAYMENT  
 11 FOR RURAL EMERGENCY ACCESS CARE HOSPITAL  
 12 SERVICES.—The amount of payment for rural emer-  
 13 gency access care hospital services provided during  
 14 a year shall be determined using the applicable  
 15 method provided under this subsection for determin-  
 16 ing payment for outpatient rural primary care hos-  
 17 pital services during the year.”.

18 (5) EFFECTIVE DATE.—The amendments made  
 19 by this subsection shall be effective for services pro-  
 20 vided on or after the October 1, 1995.

21 **SEC. 353. MEDICARE-DEPENDENT, SMALL RURAL HOS-**  
 22 **PITALS.**

23 (a) CLARIFICATION OF ADDITIONAL PAYMENT.—  
 24 Section 1886(d)(5)(G)(ii)(I) of the Social Security Act (42  
 25 U.S.C. 1395ww(d)(5)(G)(ii)(I)) is amended by striking

1 “the first 3 12-month cost reporting periods that begin”  
2 and inserting “the 36-month period beginning with the  
3 first day of the cost reporting period that begins”.

4 (b) SPECIAL TREATMENT EXTENDED.—Section  
5 1886(d)(5)(G) of such Act (42 U.S.C. 1395ww(d)(5)(G))  
6 is amended—

7 (1) in clause (i), by striking “October 1, 1994”  
8 and inserting “October 1, 1999”; and

9 (2) in clause (ii)(II), by striking “October 1,  
10 1994” and inserting “October 1, 1999”.

11 (c) EXTENSION OF TARGET AMOUNT.—Section  
12 1886(b)(3)(D) of such Act (42 U.S.C. 1395ww(b)(3)(D))  
13 is amended—

14 (1) in the matter preceding clause (i), by strik-  
15 ing “March 31, 1993” and inserting “September 30,  
16 1999”; and

17 (2) by amending clause (iii) to read as follows:

18 “(iii) with respect to discharges occurring in fis-  
19 cal years 1994 through 1999, the target amount for  
20 the cost reporting period beginning in the previous  
21 fiscal year increased by the applicable percentage in-  
22 crease under subparagraph (B)(iv).”.

1 **SEC. 354. EXPANDED COVERAGE FOR PHYSICIAN ASSIST-**  
2 **ANTS AND NURSE PRACTITIONERS.**

3 (a) COVERAGE IN OUTPATIENT SETTINGS.—(1) Sec-  
4 tion 1861(s)(2)(K) of the Social Security Act (42 U.S.C.  
5 1395x(s)(2)(K)) is amended—

6 (A) in clause (i)—

7 (i) by striking “or” at the end of  
8 subclause (II); and

9 (ii) by inserting “or (IV) in an out-  
10 patient setting as defined by the Sec-  
11 retary” following “shortage area,”; and

12 (B) in clause (ii), by striking “in a skilled  
13 nursing facility or nursing facility (as defined in  
14 section 1919(a)” and inserting “(I) in a skilled  
15 nursing facility or nursing facility (as defined in  
16 section 1919(a)), or (II) in an outpatient set-  
17 ting as defined by the Secretary”.

18 (2) Section 1833(r)(1) of such Act (42 U.S.C.  
19 1395l(r)(1)) is amended by striking “rural area)”  
20 and inserting “rural area), or for services described  
21 in section 1861(s)(2)(K)(ii)(II) (relating to nurse  
22 practitioner services in an outpatient settings)”.

23 (3) Section 1842(b)(6)(C) (42 U.S.C.  
24 1395u(b)(6)(C)) is amended by striking “(ii)” and  
25 inserting “(ii)(II)”.

1       (b) PAYMENT BASED ON PHYSICIAN FEE SCHED-  
2 ULE.—

3           (1) Section 1833(a)(1)(O) of such Act (42  
4 U.S.C. 1395l(a)(1)(O)) is amended—

5               (A) by striking “section 1861(s)(2)(K)(iii)  
6               (relating to nurse practitioner and clinical nurse  
7               specialist services provided in a rural area)”  
8               and inserting “section 1861(s)(2)(K)”;

9               (B) by striking “for services furnished on  
10              or after January 1, 1992,” and inserting “for  
11              services described in section 1861(s)(2)(K)(iii)  
12              furnished on or after January 1, 1992, and for  
13              services described in clauses (i), (ii), and (iv) of  
14              section 1861(s)(2)(K) furnished on or after  
15              January 1, 1997,”; and

16              (C) by striking “subsection (r)(2)” and in-  
17              serting “subsection (r)(2) or subparagraph (A)  
18              or (B) of section 1842(b)(12)”.

19           (2) Section 1842(b)(12)(A) of such Act (42  
20 U.S.C. 1395u(b)(12)(A)) is amended—

21               (A) by striking “and” at the end of clause  
22               (i);

23               (B) in clause (ii) in the matter preceding  
24               subclause (I), by striking “the prevailing” and

1 inserting “for services furnished before January  
2 1, 1997, the prevailing”;

3 (C) by striking the period at the end of  
4 clause (ii)(II) and inserting “; and”; and

5 (D) by inserting at the end the following  
6 clause:

7 “(iii) in the case of services furnished  
8 on or after January 1, 1997, the fee sched-  
9 ule amount shall be equal to—

10 “(I) in the case of services per-  
11 formed as an assistant at surgery, 65  
12 percent of the amount that would oth-  
13 erwise be recognized if performed by a  
14 physician who is serving as an assist-  
15 ance at surgery,

16 “(II) in the case of services per-  
17 formed (other than as an assistant at  
18 surgery) in a hospital, 75 percent of  
19 the fee schedule amount specified  
20 under section 1848, and

21 “(III) in the case of other serv-  
22 ices, 85 percent of the fee schedule  
23 amount specified under section 1848.

24 (c) RURAL NURSE PRACTITIONERS AS ASSISTANTS  
25 AT SURGERY IN URBAN AREAS.—Section

1 1861(s)(2)(K)(ii) of such Act (42 U.S.C.  
2 1395x(s)(2)(K)(ii)), as amended by subsection (a)(2), is  
3 further amended by adding “or services as an assistant  
4 at surgery furnished by a nurse practitioner whose pri-  
5 mary practice location (as defined by the Secretary) is in  
6 a rural area (as defined in section 1886(d)(2)(D)) to an  
7 individual who resides in a rural area when the service  
8 is furnished to such individual in an urban area by such  
9 practitioner when such practitioner refers such individual  
10 to an urban area for the furnishing of services” after “as  
11 defined by the Secretary”.

12 (d) CONFORMING AMENDMENTS.—

13 (1) Section 1861(b)(4) of such Act (42 U.S.C.  
14 1395x(b)(4)) is amended by striking “subsection  
15 (s)(2)(K)(i)” and inserting “subsection (s)(2)(K)”.

16 (2) Section 1862(a)(14) of such Act (42 U.S.C.  
17 1395y(a)(14)), as amended by section 620(b)(4)(K),  
18 is amended by striking “section 1861(s)(2)(K)(i)”  
19 and inserting “section 1861(s)(2)(K)”.

20 (3) Section 1866(a)(1)(H) of such Act (42  
21 U.S.C. 1395cc(a)(1)(H)), is amended by striking  
22 “section 1861(s)(2)(K)(i)” and inserting “section  
23 1861(s)(2)(K)”.

1 (e) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to services furnished on or after  
3 January 1, 1997.

4 **Subtitle F—Emergency Medical**  
5 **Systems**

6 **SEC. 361. GRANTS TO STATES REGARDING AIRCRAFT FOR**  
7 **TRANSPORTING RURAL VICTIMS OF MEDICAL**  
8 **EMERGENCIES.**

9 Part E of title XII of the Public Health Service Act  
10 (42 U.S.C. 300d–51 et seq.) is amended by adding at the  
11 end thereof the following new section:

12 **“SEC. 1252. GRANTS FOR SYSTEMS TO TRANSPORT RURAL**  
13 **VICTIMS OF MEDICAL EMERGENCIES.**

14 “(a) IN GENERAL.—The Secretary shall make grants  
15 to States to assist such States in the creation or enhance-  
16 ment of air medical transport systems that provide victims  
17 of medical emergencies in rural areas with access to treat-  
18 ments for the injuries or other conditions resulting from  
19 such emergencies.

20 “(b) APPLICATION AND PLAN.—

21 “(1) APPLICATION.—To be eligible to receive a  
22 grant under subsection (a), a State shall prepare  
23 and submit to the Secretary an application in such  
24 form, made in such manner, and containing such  
25 agreements, assurances, and information, including



1 a State plan as required in paragraph (2), as the  
2 Secretary determines to be necessary to carry out  
3 this section.

4 “(2) STATE PLAN.—An application submitted  
5 under paragraph (1) shall contain a State plan that  
6 shall—

7 “(A) describe the intended uses of the  
8 grant proceeds and the geographic areas to be  
9 served;

10 “(B) demonstrate that the geographic  
11 areas to be served, as described under subpara-  
12 graph (A), are rural in nature;

13 “(C) demonstrate that there is a lack of  
14 facilities available and equipped to deliver ad-  
15 vanced levels of medical care in the geographic  
16 areas to be served;

17 “(D) demonstrate that in utilizing the  
18 grant proceeds for the establishment or en-  
19 hancement of air medical services the State  
20 would be making a cost-effective improvement  
21 to existing ground-based or air emergency medi-  
22 cal service systems;

23 “(E) demonstrate that the State will not  
24 utilize the grant proceeds to duplicate the capa-  
25 bilities of existing air medical systems that are

1 effectively meeting the emergency medical needs  
2 of the populations they serve;

3 “(F) demonstrate that in utilizing the  
4 grant proceeds the State is likely to achieve a  
5 reduction in the morbidity and mortality rates  
6 of the areas to be served, as determined by the  
7 Secretary;

8 “(G) demonstrate that the State, in utiliz-  
9 ing the grant proceeds, will—

10 “(i) maintain the expenditures of the  
11 State for air and ground medical transport  
12 systems at a level equal to not less than  
13 the level of such expenditures maintained  
14 by the State for the fiscal year preceding  
15 the fiscal year for which the grant is re-  
16 ceived; and

17 “(ii) ensure that recipients of direct  
18 financial assistance from the State under  
19 such grant will maintain expenditures of  
20 such recipients for such systems at a level  
21 at least equal to the level of such expendi-  
22 tures maintained by such recipients for the  
23 fiscal year preceding the fiscal year for  
24 which the financial assistance is received;

1           “(H) demonstrate that persons experienced  
2           in the field of air medical service delivery were  
3           consulted in the preparation of the State plan;  
4           and

5           “(I) contain such other information as the  
6           Secretary may determine appropriate.

7           “(c) CONSIDERATIONS IN AWARDING GRANTS.—In  
8           determining whether to award a grant to a State under  
9           this section, the Secretary shall—

10           “(1) consider the rural nature of the areas to  
11           be served with the grant proceeds and the services  
12           to be provided with such proceeds, as identified in  
13           the State plan submitted under subsection (b); and

14           “(2) give preference to States with State plans  
15           that demonstrate an effective integration of the pro-  
16           posed air medical transport systems into a com-  
17           prehensive network or plan for regional or statewide  
18           emergency medical service delivery.

19           “(d) STATE ADMINISTRATION AND USE OF  
20           GRANT.—

21           “(1) IN GENERAL.—The Secretary may not  
22           make a grant to a State under subsection (a) unless  
23           the State agrees that such grant will be adminis-  
24           tered by the State agency with principal responsibil-  
25           ity for carrying out programs regarding the provi-

1 sion of medical services to victims of medical emer-  
2 gencies or trauma.

3 “(2) PERMITTED USES.—A State may use  
4 amounts received under a grant awarded under this  
5 section to award subgrants to public and private en-  
6 tities operating within the State.

7 “(3) OPPORTUNITY FOR PUBLIC COMMENT.—  
8 The Secretary may not make a grant to a State  
9 under subsection (a) unless that State agrees that,  
10 in developing and carrying out the State plan under  
11 subsection (b)(2), the State will provide public notice  
12 with respect to the plan (including any revisions  
13 thereto) and facilitate comments from interested  
14 persons.

15 “(e) NUMBER OF GRANTS.—The Secretary shall  
16 award grants under this section to not less than 7 States.

17 “(f) REPORTS.—

18 “(1) REQUIREMENT.—A State that receives a  
19 grant under this section shall annually (during each  
20 year in which the grant proceeds are used) prepare  
21 and submit to the Secretary a report that shall con-  
22 tain—

23 “(A) a description of the manner in which  
24 the grant proceeds were utilized;

1           “(B) a description of the effectiveness of  
2           the air medical transport programs assisted  
3           with grant proceeds; and

4           “(C) such other information as the Sec-  
5           retary may require.

6           “(2) TERMINATION OF FUNDINGS.—In review-  
7           ing reports submitted under paragraph (1), if the  
8           Secretary determines that a State is not using  
9           amounts provided under a grant awarded under this  
10          section in accordance with the State plan submitted  
11          by the State under subsection (b), the Secretary may  
12          terminate the payment of amounts under such grant  
13          to the State until such time as the Secretary deter-  
14          mines that the State comes into compliance with  
15          such plan.

16          “(g) DEFINITION.—As used in this section, the term  
17          ‘rural areas’ means geographic areas that are located out-  
18          side of standard metropolitan statistical areas, as identi-  
19          fied by the Secretary.

20          “(h) AUTHORIZATION OF APPROPRIATIONS.—There  
21          are authorized to be appropriated to make grants under  
22          this section, \$15,000,000 for fiscal year 1995, and such  
23          sums as may be necessary for each for fiscal years 1996  
24          and 1997.”.

# 1     **Subtitle G—Studies and Reports**

## 2     **SEC. 371. ASSISTANT SECRETARY FOR RURAL HEALTH.**

3         (a) APPOINTMENT OF ASSISTANT SECRETARY.—

4             (1) IN GENERAL.—Section 711(a) of the Social  
5         Security Act (42 U.S.C. 912(a)) is amended—

6             (A) by striking “by a Director, who shall  
7             advise the Secretary” and inserting “by an As-  
8             sistant Secretary for Rural Health (in this sec-  
9             tion referred to as the ‘Assistant Secretary’),  
10            who shall report directly to the Secretary”; and

11            (B) by adding at the end the following new  
12            sentence: “The Office shall not be a component  
13            of any other office, service, or component of the  
14            Department.”.

15            (2) CONFORMING AMENDMENTS.—(A) Section  
16         711(b) of the Social Security Act (42 U.S.C. 912(b))  
17         is amended by striking “the Director” and inserting  
18         “the Assistant Secretary”.

19            (B) Section 338J(a) of the Public Health Serv-  
20         ice Act (42 U.S.C. 254r(a)) is amended by striking  
21         “Director of the Office of Rural Health Policy” and  
22         inserting “Assistant Secretary for Rural Health”.

23            (C) Section 464T(b) of the Public Health Serv-  
24         ice Act (42 U.S.C. 285p–2(b)) is amended in the  
25         matter preceding paragraph (1) by striking “Direc-

1       tor of the Office of Rural Health Policy” and insert-  
2       ing “Assistant Secretary for Rural Health”.

3           (D) Section 6213 of the Omnibus Budget Rec-  
4       onciliation Act of 1989 (42 U.S.C. 1395x note) is  
5       amended in subsection (e)(1) by striking “Director  
6       of the Office of Rural Health Policy” and inserting  
7       “Assistant Secretary for Rural Health”.

8           (E) Section 403 of the Ryan White Comprehen-  
9       sive AIDS Resources Emergency Act of 1990 (42  
10      U.S.C. 300ff–11 note) is amended in the matter pre-  
11     ceding paragraph (1) of subsection (a) by striking  
12     “Director of the Office of Rural Health Policy” and  
13     inserting “Assistant Secretary for Rural Health”.

14          (3) AMENDMENT TO THE EXECUTIVE SCHED-  
15      ULE.—Section 5315 of title 5, United States Code,  
16      is amended by striking “Assistant Secretaries of  
17      Health and Human Services (5)” and inserting “As-  
18      sistant Secretaries of Health and Human Services  
19      (6)”.

20          (b) EXPANSION OF DUTIES.—Section 711(a) of the  
21      Social Security Act (42 U.S.C. 912(a)) is amended by  
22      striking “and access to (and the quality of) health care  
23      in rural areas” and inserting “access to, and quality of,  
24      health care in rural areas, and reforms to the health care

1 system and the implications of such reforms for rural  
2 areas”.

3 (c) EFFECTIVE DATE.—The amendments made by  
4 this section shall take effect on January 1, 1996.

5 **SEC. 372. STUDY ON TRANSITIONAL MEASURES TO ENSURE**  
6 **ACCESS.**

7 (a) IN GENERAL.—The Prospective Payment Assess-  
8 ment Commission shall conduct a study concerning the  
9 need for legislation or regulations to ensure that vulner-  
10 able populations have adequate access to health plans and  
11 health care providers and services.

12 (b) REPORT.—Not later than 1 year after the date  
13 of enactment of this Act, the Prospective Payment Assess-  
14 ment Commission shall prepare and submit to Congress  
15 a report concerning the findings and recommendations of  
16 the Commission based on the study conducted under sub-  
17 section (a).

18 **SEC. 373. STUDY ON EXPANDING BENEFITS UNDER HEALTH**  
19 **PLANS FOR INDIVIDUALS RESIDING IN**  
20 **RURAL AREAS.**

21 (a) STUDY.—

22 (1) IN GENERAL.—The Secretary shall conduct  
23 a study on the possible benefits of a program under  
24 which issuers of health plans covering individuals  
25 who reside in rural areas may—



1 (A) develop a package of benefits targeted  
 2 at improving access to health care services  
 3 which would supplement the benefits included  
 4 under such plan; and

5 (B) receive premium payments for such  
 6 package of benefits from the Secretary under  
 7 the Medicare or Medicaid programs.

8 (2) CONSULTATION WITH CERTAIN ENTITIES.—

9 In conducting the study under paragraph (1), the  
 10 Secretary shall consult with the Office of Rural  
 11 Health Policy and private and public entities with  
 12 expertise in rural health issues.

13 (b) REPORT.—Not later than 1 year after the date  
 14 of the enactment of this Act the Secretary shall submit  
 15 a report to Congress containing the results of the study  
 16 conducted under subsection (a) and any legislative rec-  
 17 ommendations determined appropriate by the Secretary.

## 18 **TITLE IV—LONG-TERM CARE** 19 **PROVISIONS**

20 **SEC. 400. AMENDMENT OF INTERNAL REVENUE CODE OF**  
 21 **1986.**

22 Except as otherwise expressly provided, whenever in  
 23 this title an amendment or repeal is expressed in terms  
 24 of an amendment to, or repeal of, a section or other provi-  
 25 sion, the reference shall be considered to be made to a

1 section or other provision of the Internal Revenue Code  
2 of 1986.

## 3           **Subtitle A—Long-Term Care** 4           **Services and Contracts**

### 5           **PART I—GENERAL PROVISIONS**

#### 6   **SEC. 401. QUALIFIED LONG-TERM CARE SERVICES TREAT-** 7           **ED AS MEDICAL CARE.**

8           (a) GENERAL RULE.—Paragraph (1) of section  
9 213(d) (defining medical care) is amended by striking  
10 “or” at the end of subparagraph (B), by redesignating  
11 subparagraph (C) as subparagraph (D), and by inserting  
12 after subparagraph (B) the following new subparagraph:

13                   “(C) for qualified long-term care services  
14                   (as defined in subsection (g)), or”.

15           (b) QUALIFIED LONG-TERM CARE SERVICES DE-  
16 FINED.—Section 213 (relating to deduction for medical,  
17 dental, etc. expenses), as amended by section 101, is  
18 amended by adding at the end the following new sub-  
19 section:

20                   “(g) QUALIFIED LONG-TERM CARE SERVICES.—For  
21 purposes of this section—

22                           “(1) IN GENERAL.—The term ‘qualified long-  
23 term care services’ means necessary diagnostic, pre-  
24 ventive, therapeutic, rehabilitative, and maintenance  
25 (including personal care) services—

1           “(A) which are required by an individual  
2           during any period during which such individual  
3           is a functionally impaired individual,

4           “(B) which have as their primary purpose  
5           the provision of needed assistance with 1 or  
6           more activities of daily living which a function-  
7           ally impaired individual is certified as being un-  
8           able to perform under paragraph (2)(A), and

9           “(C) which are provided pursuant to a con-  
10          tinuing plan of care prescribed by a licensed  
11          health care practitioner (other than a relative of  
12          such individual).

13          “(2) FUNCTIONALLY IMPAIRED INDIVIDUAL.—

14               “(A) IN GENERAL.—The term ‘functionally  
15               impaired individual’ means any individual who  
16               is certified by a licensed health care practitioner  
17               (other than a relative of such individual) as  
18               being unable to perform, without substantial as-  
19               sistance from another individual (including as-  
20               sistance involving verbal reminding, physical  
21               cueing, or substantial supervision), at least 3  
22               activities of daily living described in paragraph  
23               (3).

24               “(B) SPECIAL RULE FOR HOME HEALTH  
25               CARE SERVICES.—In the case of services which

1 are provided during any period during which an  
2 individual is residing within the individual's  
3 home (whether or not the services are provided  
4 within the home), subparagraph (A) shall be  
5 applied by substituting '2' for '3'. For purposes  
6 of this subparagraph, a nursing home or similar  
7 facility shall not be treated as a home.

8 “(3) ACTIVITIES OF DAILY LIVING.—Each of  
9 the following is an activity of daily living:

10 “(A) Eating.

11 “(B) Transferring.

12 “(C) Toileting.

13 “(D) Dressing.

14 “(E) Bathing.

15 “(4) LICENSED HEALTH CARE PRACTI-  
16 TIONER.—

17 “(A) IN GENERAL.—The term 'licensed  
18 health care practitioner' means—

19 “(i) a physician or registered profes-  
20 sional nurse,

21 “(ii) a qualified community care case  
22 manager (as defined in subparagraph (B)),  
23 or

24 “(iii) any other individual who meets  
25 such requirements as may be prescribed by

1 the Secretary after consultation with the  
2 Secretary of Health and Human Services.

3 “(B) QUALIFIED COMMUNITY CARE CASE  
4 MANAGER.—The term ‘qualified community  
5 care case manager’ means an individual or en-  
6 tity which—

7 “(i) has experience or has been  
8 trained in providing case management  
9 services and in preparing individual care  
10 plans;

11 “(ii) has experience in assessing indi-  
12 viduals to determine their functional and  
13 cognitive impairment;

14 “(iii) is not a relative of the individual  
15 receiving case management services; and

16 “(iv) meets such requirements as may  
17 be prescribed by the Secretary after con-  
18 sultation with the Secretary of Health and  
19 Human Services.

20 “(5) RELATIVE.—The term ‘relative’ means an  
21 individual bearing a relationship to another individ-  
22 ual which is described in paragraphs (1) through (8)  
23 of section 152(a).”

24 (c) TECHNICAL AMENDMENTS.—

1           (1) Subparagraph (D) of section 213(d)(1) (as  
2       redesignated by subsection (a)) is amended to read  
3       as follows:

4           “(D) for insurance (including amounts  
5       paid as premiums under part B of title XVIII  
6       of the Social Security Act, relating to supple-  
7       mentary medical insurance for the aged)—

8           “(i) covering medical care referred to  
9       in subparagraphs (A) and (B), or

10          “(ii) covering medical care referred to  
11       in subparagraph (C), but only if such cov-  
12       erage is provided under a qualified long-  
13       term care insurance contract (as defined in  
14       section 7702B(b)).”

15          (2) Paragraph (6) of section 213(d) is amend-  
16       ed—

17           (A) by striking “subparagraphs (A) and  
18       (B)” in the matter preceding subparagraph (A)  
19       and inserting “subparagraphs (A), (B), and  
20       (C)”, and

21           (B) by striking “paragraph (1)(C)” in sub-  
22       paragraph (A) and inserting “paragraph  
23       (1)(D)”.

1           (3) Paragraph (7) of section 213(d) is amended  
2           by striking “subparagraphs (A) and (B)” and insert-  
3           ing “subparagraphs (A), (B), and (C)”.

4   **SEC. 402. TREATMENT OF LONG-TERM CARE INSURANCE**  
5                           **OR PLANS.**

6           (a) GENERAL RULE.—Chapter 79 (relating to defini-  
7           tions) is amended by inserting after section 7702A the fol-  
8           lowing new section:

9   **“SEC. 7702B. TREATMENT OF LONG-TERM CARE INSURANCE**  
10                           **OR PLANS.**

11           “(a) GENERAL RULE.—For purposes of this title—

12                   “(1) a qualified long-term care insurance con-  
13           tract shall be treated as an accident or health insur-  
14           ance contract,

15                   “(2) any plan of an employer providing cov-  
16           erage of qualified long-term care services shall be  
17           treated as an accident or health plan with respect to  
18           such services,

19                   “(3) amounts received under such a contract or  
20           plan with respect to qualified long-term care services  
21           shall be treated as amounts received for personal in-  
22           juries or sickness, and

23                   “(4) payments described in subsection (b)(5)  
24           shall be treated as payments made with respect to  
25           qualified long-term care services.

1       “(b) QUALIFIED LONG-TERM CARE INSURANCE  
2 CONTRACT.—

3               “(1) IN GENERAL.—For purposes of this title,  
4 the term ‘qualified long-term care insurance con-  
5 tract’ means any insurance contract if—

6                       “(A) the only insurance protection pro-  
7 vided under such contract is coverage of quali-  
8 fied long-term care services,

9                       “(B) such contract meets the requirements  
10 of paragraphs (2), (3), and (4), and

11                      “(C) such contract is issued by a qualified  
12 issuer.

13       “(2) PREMIUM REQUIREMENTS.—

14               “(A) IN GENERAL.—The requirements of  
15 this paragraph are met with respect to a con-  
16 tract if such contract provides that—

17                      “(i) premium payments may not be  
18 made earlier than the date such payments  
19 would have been made if the contract pro-  
20 vided for level annual payments over the  
21 life of the contract (or, if shorter, 20  
22 years), and

23                      “(ii) all refunds of premiums, and all  
24 policyholder dividends or similar amounts,  
25 under such contract are to be applied as a



1 reduction in future premiums or to in-  
2 crease future benefits.

3 A contract shall not be treated as failing to  
4 meet the requirements of clause (i) solely by  
5 reason of a provision providing for a waiver of  
6 premiums if the policyholder becomes a func-  
7 tionally impaired individual.

8 “(B) REFUNDS UPON DEATH OR COM-  
9 PLETE SURRENDER OR CANCELLATION.—Sub-  
10 paragraph (A)(ii) shall not apply to any refund  
11 on the death of the policyholder, or on any com-  
12 plete surrender or cancellation of the contract,  
13 if, under the contract, the amount refunded  
14 may not exceed the amount of the premiums  
15 paid under the contract. For purposes of this  
16 title, any refund described in the preceding sen-  
17 tence shall be includible in gross income to the  
18 extent that any deduction or exclusion was al-  
19 lowed with respect to the refund.

20 “(3) BORROWING, PLEDGING, OR ASSIGNING  
21 PROHIBITED.—The requirements of this paragraph  
22 are met with respect to a contract if such contract  
23 provides that no money may be borrowed under such  
24 contract and that such contract (or any portion

1       thereof) may not be assigned or pledged as collateral  
2       for a loan.

3           “(4) PROHIBITION OF DUPLICATE PAYMENT.—  
4       The requirements of this paragraph are met with re-  
5       spect to a contract if such contract does not cover  
6       expenses incurred to the extent that such expenses  
7       are reimbursable under title XVIII of the Social Se-  
8       curity Act.

9           “(5) PER DIEM AND OTHER PERIODIC PAY-  
10       MENTS PERMITTED.—

11           “(A) IN GENERAL.—For purposes of sub-  
12       section (a)(4), and except as provided in sub-  
13       paragraph (B), payments are described in this  
14       paragraph for any calendar year if, under the  
15       contract, such payments are made to (or on be-  
16       half of) a functionally impaired individual on a  
17       per diem or other periodic basis without regard  
18       to the expenses incurred or services rendered  
19       during the period to which the payments relate.

20           “(B) EXCEPTION WHERE AGGREGATE PAY-  
21       MENTS EXCEED LIMIT.—If the aggregate pay-  
22       ments under the contract for any period  
23       (whether on a periodic basis or otherwise) ex-  
24       ceed the dollar amount in effect for such pe-  
25       riod—

1           “(i) subparagraph (A) shall not apply  
2           for such period, and

3           “(ii) the requirements of paragraph  
4           (1)(A) shall be met only if such payments  
5           are made with respect to qualified long-  
6           term care services provided during such  
7           period.

8           “(C) DOLLAR AMOUNT.—The dollar  
9           amount in effect under this paragraph shall be  
10          \$150 per day (or the equivalent amount in the  
11          case of payments on another periodic basis).

12          “(D) ADJUSTMENTS FOR INCREASED  
13          COSTS.—

14               “(i) IN GENERAL.—In the case of any  
15               calendar year after 1995, the dollar  
16               amount in effect under subparagraph (C)  
17               for any period occurring during such cal-  
18               endar year shall be equal to the sum of—

19                       “(I) the amount in effect under  
20                       subparagraph (C) for the preceding  
21                       calendar year (after application of this  
22                       subparagraph), plus

23                               “(II) the applicable percentage of  
24                               the amount under subclause (I).

1           “(ii) APPLICABLE PERCENTAGE.—For  
 2           purposes of clause (i), the term ‘applicable  
 3           percentage’ means, with respect to any cal-  
 4           endar year, the greater of—

5                   “(I) 5 percent, or

6                   “(II) the cost-of-living adjust-  
 7                   ment for such calendar year.

8           “(iii) COST-OF-LIVING ADJUST-  
 9           MENT.—For purposes of clause (ii), the  
 10           cost-of-living adjustment for any calendar  
 11           year is the percentage (if any) by which  
 12           the cost index under clause (iv) for the  
 13           preceding calendar year exceeds such index  
 14           for the second preceding calendar year. In  
 15           the case of any calendar year beginning be-  
 16           fore 1997, this clause shall be applied by  
 17           substituting the Consumer Price Index (as  
 18           defined in section 1(f)(5)) for the cost  
 19           index under clause (iv).

20           “(iv) COST INDEX.—The Secretary, in  
 21           consultation with the Secretary of Health  
 22           and Human Services, shall before January  
 23           1, 1997, establish a cost index to measure  
 24           increases in costs of nursing home and  
 25           similar facilities. The Secretary may from

1           time to time revise such index to the extent  
2           necessary to accurately measure increases  
3           or decreases in such costs.

4           “(E) AGGREGATION RULE.—For purposes  
5           of this paragraph, all contracts issued with re-  
6           spect to the same policyholder by the same  
7           company shall be treated as 1 contract.

8           “(c) QUALIFIED ISSUER.—For purposes of this sec-  
9           tion, the term ‘qualified issuer’ means any person which  
10          at the time of the issuance of a long-term care insurance  
11          contract—

12           “(1) uses a one year preliminary term method  
13          for setting up reserves, and

14           “(2) maintains a capital ratio equal to not less  
15          than 25 percent of long-term care insurance pre-  
16          mium receivables.

17          “(d) SPECIAL RULES FOR TAX TREATMENT OF POL-  
18          ICYHOLDERS.—For purposes of this title, solely with re-  
19          spect to the policyholder under any qualified long-term  
20          care insurance contract—

21           “(1) AGGREGATE PAYMENTS IN EXCESS OF  
22          LIMITS.—If the aggregate payments under all quali-  
23          fied long-term care insurance contracts with respect  
24          to an policyholder for any period (whether on a peri-

1        odic basis or otherwise) exceed the dollar amount in  
2        effect for such period under subsection (b)(5)—

3                “(A) subsection (b)(5) shall not apply for  
4                such period, and

5                “(B) such payments shall be treated as  
6                made for qualified long-term care services only  
7                if made with respect to such services provided  
8                during such period.

9                “(2) ASSIGNMENT OR PLEDGE.—Such contract  
10       shall not be treated as a qualified long-term care in-  
11       surance contract during any period on or after the  
12       date on which the contract (or any portion thereof)  
13       is assigned or pledged as collateral for a loan.

14       “(e) TREATMENT OF COVERAGE AS PART OF A LIFE  
15       INSURANCE CONTRACT.—Except as provided in regula-  
16       tions, in the case of coverage of qualified long-term care  
17       services provided as part of a life insurance contract, the  
18       requirements of this section shall apply as if the portion  
19       of the contract providing such coverage was a separate  
20       contract.

21       “(f) QUALIFIED LONG-TERM CARE SERVICES.—For  
22       purposes of this section—

23                “(1) IN GENERAL.—The term ‘qualified long-  
24       term care services’ has the meaning given such term  
25       by section 213(g).

1           “(2) RECERTIFICATION.—If an individual has  
 2       been certified as a functionally impaired individual  
 3       under section 213(g)(2)(A), services shall not be  
 4       treated as qualified long-term care services with re-  
 5       spect to the individual unless such individual is  
 6       recertified no less frequently than annually as a  
 7       functionally impaired individual in the same manner  
 8       as under such section, except that such  
 9       recertification may be made by any licensed health  
 10      care practitioner (as defined in section 213(g)(4)),  
 11      other than a relative (as defined by section  
 12      213(g)(5)) of such individual.

13       “(g) CONTINUATION COVERAGE EXCISE TAX NOT  
 14      TO APPLY.—Section 4980B shall not apply to—

15           “(1) qualified long-term care insurance con-  
 16      tracts, or

17           “(2) plans described in subsection (a)(2).

18       “(h) REGULATIONS.—The Secretary shall prescribe  
 19      such regulations as may be necessary to carry out the re-  
 20      quirements of this section, including regulations to prevent  
 21      the avoidance of this section by providing qualified long-  
 22      term care services under a life insurance contract.”

23       “(b) CAFETERIA PLANS.—Section 125(f) is amended  
 24      by adding at the end the following new sentence: “Such  
 25      term does not include any coverage or benefits under a

1 qualified long-term care insurance contract (as defined in  
2 section 7702B).”

3 (c) RESERVES.—Clause (iii) of section 807(d)(3)(A)  
4 is amended by inserting “(other than a qualified long-term  
5 care insurance contract within the meaning of section  
6 7702B)” after “contract”.

7 (d) CLERICAL AMENDMENT.—The table of sections  
8 for chapter 79 is amended by inserting after the item re-  
9 lating to section 7702A the following new item:

“Sec. 7702B. Treatment of long-term care insurance or plans.”

10 **SEC. 403. EFFECTIVE DATES.**

11 (a) SECTION 401.—The amendments made by section  
12 401 shall apply to taxable years beginning after December  
13 31, 1994.

14 (b) SECTION 402.—The amendments made by sec-  
15 tion 402 shall apply to contracts issued after December  
16 31, 1994.

17 (c) TRANSITION RULE.—If, after the date of the en-  
18 actment of this Act and before January 1, 1995, a con-  
19 tract providing coverage for services which are similar to  
20 qualified long-term care services (as defined in section  
21 213(g) of the Internal Revenue Code of 1986) and issued  
22 on or before January 1, 1994, is exchanged for a qualified  
23 long-term care insurance contract (as defined in section  
24 7702B(b) of such Code), such exchange shall be treated



1 as an exchange to which section 1035 of such Code ap-  
 2 plies.

## 3 **PART II—CONSUMER PROTECTION PROVISIONS**

### 4 **SEC. 406. POLICY REQUIREMENTS.**

5 (a) IN GENERAL.—Section 7702B (as added by sec-  
 6 tion 402) is amended by redesignating subsection (h) as  
 7 subsection (i) and by inserting after subsection (g) the fol-  
 8 lowing new subsection:

9 “(h) CONSUMER PROTECTION PROVISIONS.—

10 “(1) IN GENERAL.—The requirements of this  
 11 subsection are met with respect to any contract if  
 12 any long-term care insurance policy issued under the  
 13 contract meets—

14 “(A) the requirements of the model regula-  
 15 tion and model Act described in paragraph (2),

16 “(B) the disclosure requirement of para-  
 17 graph (3),

18 “(C) the requirements relating to  
 19 nonforfeitability under paragraph (4), and

20 “(D) the requirements relating to rate sta-  
 21 bilization under paragraph (5).

22 “(2) REQUIREMENTS OF MODEL REGULATION  
 23 AND ACT.—

1           “(A) IN GENERAL.—The requirements of  
2           this paragraph are met with respect to any pol-  
3           icy if such policy meets—

4           “(i) MODEL REGULATION.—The fol-  
5           lowing requirements of the model regula-  
6           tion:

7                   “(I) Section 7A (relating to guar-  
8                   anteed renewal or noncancellability),  
9                   and the requirements of section 6B of  
10                  the model Act relating to such section  
11                  7A.

12                  “(II) Section 7B (relating to pro-  
13                  hibitions on limitations and exclu-  
14                  sions).

15                  “(III) Section 7C (relating to ex-  
16                  tension of benefits).

17                  “(IV) Section 7D (relating to  
18                  continuation or conversion of cov-  
19                  erage).

20                  “(V) Section 7E (relating to dis-  
21                  continuance and replacement of poli-  
22                  cies).

23                  “(VI) Section 8 (relating to unin-  
24                  tentional lapse).

1 “(VII) Section 9 (relating to dis-  
2 closure), other than section 9F there-  
3 of.

4 “(VIII) Section 10 (relating to  
5 prohibitions against post-claims un-  
6 derwriting).

7 “(IX) Section 11 (relating to  
8 minimum standards).

9 “(X) Section 12 (relating to re-  
10 quirement to offer inflation protec-  
11 tion), except that any requirement for  
12 a signature on a rejection of inflation  
13 protection shall permit the signature  
14 to be on an application or on a sepa-  
15 rate form.

16 “(XI) Section 23 (relating to pro-  
17 hibition against preexisting conditions  
18 and probationary periods in replace-  
19 ment policies or certificates).

20 “(ii) MODEL ACT.—The following re-  
21 quirements of the model Act:

22 “(I) Section 6C (relating to pre-  
23 existing conditions).

24 “(II) Section 6D (relating to  
25 prior hospitalization).

1           “(B) DEFINITIONS.—For purposes of this  
2 paragraph—

3           “(i) MODEL PROVISIONS.—The terms  
4           ‘model regulation’ and ‘model Act’ mean  
5           the long-term care insurance model regula-  
6           tion, and the long-term care insurance  
7           model Act, respectively, promulgated by  
8           the National Association of Insurance  
9           Commissioners (as adopted in January of  
10          1993).

11          “(ii) COORDINATION.—Any provision  
12          of the model regulation or model Act listed  
13          under clause (i) or (ii) of subparagraph  
14          (A) shall be treated as including any other  
15          provision of such regulation or Act nec-  
16          essary to implement the provision.

17          “(3) TAX DISCLOSURE REQUIREMENT.—The re-  
18          quirement of this paragraph is met with respect to  
19          any policy if such policy meets the requirements of  
20          section 4980C(d)(1).

21          “(4) NONFORFEITURE REQUIREMENTS.—

22               “(A) IN GENERAL.—The requirements of  
23               this paragraph are met with respect to any level  
24               premium long-term care insurance policy, if the  
25               issuer of such policy offers to the policyholder,

1 including any group policyholder, a  
2 nonforfeiture provision meeting the require-  
3 ments of subparagraph (B).

4 “(B) REQUIREMENTS OF PROVISION.—The  
5 nonforfeiture provision required under subpara-  
6 graph (A) shall meet the following require-  
7 ments:

8 “(i) The nonforfeiture provision shall  
9 be appropriately captioned.

10 “(ii) The nonforfeiture provision shall  
11 provide for a benefit available in the event  
12 of a default in the payment of any pre-  
13 miums and the amount of the benefit may  
14 be adjusted subsequent to being initially  
15 granted only as necessary to reflect  
16 changes in claims, persistency, and interest  
17 as reflected in changes in rates for pre-  
18 mium paying policies approved by the Sec-  
19 retary for the same policy form.

20 “(iii) The nonforfeiture provision shall  
21 provide at least one of the following:

22 “(I) Reduced paid-up insurance.

23 “(II) Extended term insurance.

24 “(III) Shortened benefit period.

1                   “(IV) Other similar offerings ap-  
2                   proved by the Secretary.

3                   “(5) RATE STABILIZATION.—

4                   “(A) IN GENERAL.—The requirements of  
5                   this paragraph are met with respect to any  
6                   long-term care insurance policy, including any  
7                   group master policy, if—

8                   “(i) such policy contains the minimum  
9                   rate guarantees specified in subparagraph  
10                  (B), and

11                  “(ii) the issuer of such policy meets  
12                  the requirements specified in subparagraph  
13                  (C).

14                  “(B) MINIMUM RATE GUARANTEES.—The  
15                  minimum rate guarantees specified in this sub-  
16                  paragraph are as follows:

17                  “(i) Rates under the policy shall be  
18                  guaranteed for a period of at least 3 years  
19                  from the date of issue of the policy.

20                  “(ii) After the expiration of the 3-year  
21                  period required under clause (i), any rate  
22                  increase shall be guaranteed for a period of  
23                  at least 2 years from the effective date of  
24                  such rate increase.

1           “(iii) In the case of any individual age  
2           75 or older who has maintained coverage  
3           under a long-term care insurance policy for  
4           10 years, rate increases under such policy  
5           shall not exceed 10 percent in any 12-  
6           month period.

7           “(C) INCREASES IN PREMIUMS.—The re-  
8           quirements specified in this subparagraph are  
9           as follows:

10           “(i) IN GENERAL.—If an issuer of any  
11           long-term care insurance policy, including  
12           any group master policy, plans to increase  
13           the premium rates for a policy, such issuer  
14           shall, at least 90 days before the effective  
15           date of the rate increase, offer to each in-  
16           dividual policyholder under such policy the  
17           option to remain insured under the policy  
18           at a reduced level of benefits which main-  
19           tains the premium rate at the rate in effect  
20           on the day before the effective date of the  
21           rate increase.

22           “(ii) INCREASES OF MORE THAN 50  
23           PERCENT.—

24           “(I) IN GENERAL.—If an issuer  
25           of any long-term care insurance pol-

1           icy, including any group master pol-  
2           icy, increases premium rates for a pol-  
3           icy by more than 50 percent in any 3-  
4           year period—

5                   “(aa) in the case of a group  
6                   master long-term care insurance  
7                   policy, the issuer shall dis-  
8                   continue issuing all group master  
9                   long-term care insurance policies  
10                  in any State in which the issuer  
11                  issues such policy for a period of  
12                  2 years from the effective date of  
13                  such premium increase; and

14                  “(bb) in the case of an indi-  
15                  vidual long-term care insurance  
16                  policy, the issuer shall dis-  
17                  continue issuing all individual  
18                  long-term care policies in any  
19                  State in which the issuer issues  
20                  such policy for a period of 2  
21                  years from the effective date of  
22                  such premium increase.

23                  “(II) APPLICABILITY.—Subclause  
24                  (I) shall apply to any issuer of long-  
25                  term care insurance policies or any



1           other person that purchases or other-  
2           wise acquires any long-term care in-  
3           surance policies from another issuer  
4           or person.

5           “(D) MODIFICATIONS OR WAIVERS OF RE-  
6           QUIREMENTS.—The Secretary may modify or  
7           waive any of the requirements under this para-  
8           graph if—

9           “(i) such requirements will adversely  
10          affect an issuer’s solvency;

11          “(ii) such modification or waiver is re-  
12          quired for the issuer to meet other State or  
13          Federal requirements;

14          “(iii) medical developments, new dis-  
15          abling diseases, changes in long-term care  
16          delivery, or a new method of financing  
17          long-term care will result in changes to  
18          mortality and morbidity patterns or as-  
19          sumptions;

20          “(iv) judicial interpretation of a pol-  
21          icy’s benefit features results in unintended  
22          claim liabilities; or

23          “(v) in the case of a purchase or other  
24          acquisition of long-term care insurance  
25          policies of an issuer or other person, the

1 continued sale of other long-term care in-  
 2 surance policies by the purchasing issuer  
 3 or person is in the best interests of individ-  
 4 ual consumers.

5 “(6) LONG-TERM CARE INSURANCE POLICY DE-  
 6 FINED.—For purposes of this subsection, the term  
 7 ‘long-term care insurance policy’ has the meaning  
 8 given such term by section 4980C(e).”

9 (b) CONFORMING AMENDMENT.—Section  
 10 7702B(b)(1)(B) (as added by section 402) is amended by  
 11 inserting “and of subsection (h)” after “and (4)”.

12 **SEC. 407. ADDITIONAL REQUIREMENTS FOR ISSUERS OF**  
 13 **LONG-TERM CARE INSURANCE POLICIES.**

14 (a) IN GENERAL.—Chapter 43 is amended by adding  
 15 at the end the following new section:

16 **“SEC. 4980C. FAILURE TO MEET REQUIREMENTS FOR LONG-**  
 17 **TERM CARE INSURANCE POLICIES.**

18 “(a) GENERAL RULE.—There is hereby imposed on  
 19 any person failing to meet the requirements of subsection  
 20 (c) or (d) a tax in the amount determined under sub-  
 21 section (b).

22 “(b) AMOUNT OF TAX.—

23 “(1) IN GENERAL.—The amount of the tax im-  
 24 posed by subsection (a) shall be \$100 per policy for  
 25 each day any requirements of subsection (c), (d), or

1 (e) are not met with respect to each long-term care  
2 insurance policy.

3 “(2) WAIVER.—In the case of a failure which is  
4 due to reasonable cause and not to willful neglect,  
5 the Secretary may waive part or all of the tax im-  
6 posed by subsection (a) to the extent that payment  
7 of the tax would be excessive relative to the failure  
8 involved.

9 “(c) ADDITIONAL RESPONSIBILITIES.—The require-  
10 ments of this subsection are as follows:

11 “(1) REQUIREMENTS OF MODEL PROVISIONS.—

12 “(A) MODEL REGULATION.—The following  
13 requirements of the model regulation must be  
14 met:

15 “(i) Section 13 (relating to application  
16 forms and replacement coverage).

17 “(ii) Section 14 (relating to reporting  
18 requirements), except that the issuer shall  
19 also report at least annually the number of  
20 claims denied during the reporting period  
21 for each class of business (expressed as a  
22 percentage of claims denied), other than  
23 claims denied for failure to meet the wait-  
24 ing period or because of any applicable  
25 pre-existing condition.

1           “(iii) Section 20 (relating to filing re-  
2           quirements for marketing).

3           “(iv) Section 21 (relating to standards  
4           for marketing), including inaccurate com-  
5           pletion of medical histories, other than sec-  
6           tions 21C(1) and 21C(6) thereof, except  
7           that—

8                   “(I) in addition to such require-  
9                   ments, no person shall, in selling or  
10                  offering to sell a long-term care insur-  
11                  ance policy, misrepresent a material  
12                  fact; and

13                  “(II) no such requirements shall  
14                  include a requirement to inquire or  
15                  identify whether a prospective appli-  
16                  cant or enrollee for long-term care in-  
17                  surance has accident and sickness in-  
18                  surance.

19           “(v) Section 22 (relating to appro-  
20           priateness of recommended purchase).

21           “(vi) Section 24 (relating to standard  
22           format outline of coverage).

23           “(vii) Section 25 (relating to require-  
24           ment to deliver shopper’s guide).

1           “(B) MODEL ACT.—The following require-  
2           ments of the model Act must be met:

3           “(i) Section 6F (relating to right to  
4           return), except that such section shall also  
5           apply to denials of applications and any re-  
6           fund shall be made within 30 days of the  
7           return or denial.

8           “(ii) Section 6G (relating to outline of  
9           coverage).

10          “(iii) Section 6H (relating to require-  
11          ments for certificates under group plans).

12          “(iv) Section 6I (relating to policy  
13          summary).

14          “(v) Section 6J (relating to monthly  
15          reports on accelerated death benefits).

16          “(vi) Section 7 (relating to incontest-  
17          ability period).

18          “(C) DEFINITIONS.—For purposes of this  
19          paragraph, the terms ‘model regulation’ and  
20          ‘model Act’ have the meanings given such terms  
21          by section 7702B(h)(2)(B).

22          “(2) DELIVERY OF POLICY.—If an application  
23          for a long-term care insurance policy (or for a cer-  
24          tificate under a group long-term care insurance pol-  
25          icy) is approved, the issuer shall deliver to the appli-

1 cant (or policyholder or certificate-holder) the policy  
2 (or certificate) of insurance not later than 30 days  
3 after the date of the approval.

4 “(3) INFORMATION ON DENIALS OF CLAIMS.—  
5 If a claim under a long-term care insurance policy  
6 is denied, the issuer shall, within 60 days of the date  
7 of a written request by the policyholder or certifi-  
8 cate-holder (or representative)—

9 “(A) provide a written explanation of the  
10 reasons for the denial, and

11 “(B) make available all information di-  
12 rectly relating to such denial.

13 “(d) DISCLOSURE.—The requirements of this sub-  
14 section are met if either of the following statements,  
15 whichever is applicable, is prominently displayed on the  
16 front page of any long-term care insurance policy and in  
17 the outline of coverage required under subsection  
18 (c)(1)(B)(ii):

19 “(1) A statement that: ‘This policy is intended  
20 to be a qualified long-term care insurance contract  
21 under section 7702B(b) of the Internal Revenue  
22 Code of 1986.’.

23 “(2) A statement that: ‘This policy is not in-  
24 tended to be a qualified long-term care insurance

1 contract under section 7702B(b) of the Internal  
2 Revenue Code of 1986.’.

3 “(e) LONG-TERM CARE INSURANCE POLICY DE-  
4 FINED.—For purposes of this section, the term ‘long-term  
5 care insurance policy’ means any product which is adver-  
6 tised, marketed, or offered as long-term care insurance.”

7 (b) CONFORMING AMENDMENT.—The table of sec-  
8 tions for chapter 43 is amended by adding at the end the  
9 following new item:

“Sec. 4980C. Failure to meet requirements for long-term care in-  
surance policies.”

10 **SEC. 408. COORDINATION WITH STATE REQUIREMENTS.**

11 Nothing in this part shall be construed as preventing  
12 a State from applying standards that provide greater pro-  
13 tection of policyholders of long-term care insurance poli-  
14 cies (as defined in section 4980C(e) of the Internal Reve-  
15 nue Code of 1986).

16 **SEC. 409. UNIFORM LANGUAGE AND DEFINITIONS.**

17 (a) IN GENERAL.—The National Association of In-  
18 surance Commissioners shall not later than January 1,  
19 1996, promulgate standards for the use of uniform lan-  
20 guage and definitions in long-term care insurance policies  
21 (as defined in section 4980C(e) of the Internal Revenue  
22 Code 1986).

23 (b) VARIATIONS.—Standards under subsection (a)  
24 may permit the use of nonuniform language to the extent

1 required to take into account differences among States in  
 2 the licensing of nursing facilities and other providers of  
 3 long-term care.

4 **SEC. 410. EFFECTIVE DATES.**

5 (a) IN GENERAL.—The provisions of, and amend-  
 6 ments made by, this part shall apply to contracts issued  
 7 after December 31, 1994. The provisions of section 403(c)  
 8 of this Act shall apply to such contracts.

9 (b) ISSUERS.—The amendments made by section 407  
 10 shall apply to actions taken after December 31, 1994.

11 **Subtitle B—Tax Treatment of**  
 12 **Accelerated Death Benefits**

13 **SEC. 411. TAX TREATMENT OF ACCELERATED DEATH BENE-**  
 14 **FITS UNDER LIFE INSURANCE CONTRACTS.**

15 (a) GENERAL RULE.—Section 101 (relating to cer-  
 16 tain death benefits) is amended by adding at the end the  
 17 following new subsection:

18 “(g) TREATMENT OF CERTAIN ACCELERATED  
 19 DEATH BENEFITS.—

20 “(1) IN GENERAL.—For purposes of this sec-  
 21 tion, any amount received under a life insurance  
 22 contract on the life of an insured who is a terminally  
 23 ill individual shall be treated as an amount paid by  
 24 reason of the death of such insured.

25 “(2) NECESSARY CONDITIONS.—



1           “(A) IN GENERAL.—Paragraph (1) shall  
2 not apply to any amount received unless—

3           “(i) the total amount received is not  
4 less than the present value (determined  
5 under subparagraph (B)) of the reduction  
6 in the death benefit otherwise payable in  
7 the event of the death of the insured, and

8           “(ii) the percentage reduction in the  
9 cash surrender value of the contract by  
10 reason of the distribution does not exceed  
11 the percentage reduction in the death ben-  
12 efit payable under the contract by reason  
13 of such distribution.

14           “(B) PRESENT VALUE.—The present value  
15 of the reduction in the death benefit shall be  
16 determined by—

17           “(i) using a discount rate which is  
18 based on an interest rate which does not  
19 exceed the highest interest rate set forth in  
20 subparagraph (C), and

21           “(ii) assuming that the death benefit  
22 (or the portion thereof) would have been  
23 paid on the date which is 12 months after  
24 the date of the certification referred to in  
25 paragraph (3).

1           “(C) RATES.—The interest rates set forth  
2           in this subparagraph are the following:

3                   “(i) the 90-day Treasury bill yield,

4                   “(ii) the rate described as Moody’s  
5           Corporate Bond Yield Average-Monthly  
6           Average Corporates as published by  
7           Moody’s Investors Service, Inc., or any  
8           successor thereto, for the calendar month  
9           ending 2 months before the date on which  
10          the rate is determined, and

11                  “(iii) the rate used to compute the  
12          cash surrender values under the contract  
13          during the applicable period plus 1 percent  
14          per annum.

15          “(D) SPECIAL RULES RELATING TO  
16          LIENS.—If a lien is imposed against a life in-  
17          surance contract with respect to any amount re-  
18          ferred to in paragraph (1)—

19                  “(i) for purposes of subparagraph (A),  
20          the amount of such lien shall be treated as  
21          a reduction (at the time of receipt) in the  
22          death benefit or cash surrender value to  
23          the extent that such benefit or value, as  
24          the case may be, is (or may become) sub-  
25          ject to the lien, and

1           “(ii) paragraph (1) shall not apply to  
2           the amount received unless any rate of in-  
3           terest with respect to any amount in con-  
4           nection with which such lien is imposed  
5           does not exceed the highest rate set forth  
6           in subparagraph (C).

7           “(3) TERMINALLY ILL INDIVIDUAL.—For pur-  
8           poses of this subsection, the term ‘terminally ill indi-  
9           vidual’ means an individual who the insurer has de-  
10          termined, after receipt of an acceptable certification  
11          by a licensed physician, has an illness or physical  
12          condition which can reasonably be expected to result  
13          in death within 12 months after the date of certifi-  
14          cation.

15          “(4) EXCEPTION FOR BUSINESS-RELATED POLI-  
16          CIES.—This subsection shall not apply in the case of  
17          any amount paid to any taxpayer other than the in-  
18          sured if such taxpayer has an insurable interest with  
19          respect to the life of the insured by reason of the in-  
20          sured being a director, officer, or employee of the  
21          taxpayer or by reason of the insured having a finan-  
22          cial interest in any trade or business carried on by  
23          the taxpayer.”

24          (b) EFFECTIVE DATES.—

1           (1) IN GENERAL.—Except as provided in para-  
 2           graph (2), the amendment made by this section shall  
 3           apply to amounts received after the date of the en-  
 4           actment of this Act.

5           (2) DELAY IN APPLICATION OF DISCOUNT  
 6           RULES.—Clause (i) of section 101(g)(2)(A) of the  
 7           Internal Revenue Code of 1986 shall not apply to  
 8           any amount received before January 1, 1995.

9           (3) ISSUANCE OF RIDER NOT TREATED AS MA-  
 10          TERIAL CHANGE.—For purposes of applying section  
 11          101(f), 7702, or 7702A of the Internal Revenue  
 12          Code of 1986 to any contract, the issuance of a  
 13          qualified accelerated death benefit rider (as defined  
 14          in section 818(g) of such Code (as added by this  
 15          Act)) shall not be treated as a modification or mate-  
 16          rial change of such contract.

17   **SEC. 412. TAX TREATMENT OF COMPANIES ISSUING QUALI-**  
 18                   **FIED ACCELERATED DEATH BENEFIT RID-**  
 19                   **ERS.**

20          (a) QUALIFIED ACCELERATED DEATH BENEFIT RID-  
 21          ERS TREATED AS LIFE INSURANCE.—Section 818 (relat-  
 22          ing to other definitions and special rules) is amended by  
 23          adding at the end the following new subsection:

1 “(g) QUALIFIED ACCELERATED DEATH BENEFIT  
 2 RIDERS TREATED AS LIFE INSURANCE.—For purposes of  
 3 this part—

4 “(1) IN GENERAL.—Any reference to a life in-  
 5 surance contract shall be treated as including a ref-  
 6 erence to a qualified accelerated death benefit rider  
 7 on such contract.

8 “(2) QUALIFIED ACCELERATED DEATH BENE-  
 9 FIT RIDERS.—For purposes of this subsection, the  
 10 term ‘qualified accelerated death benefit rider’  
 11 means any rider on a life insurance contract which  
 12 provides for a distribution to an individual upon the  
 13 insured becoming a terminally ill individual (as de-  
 14 fined in section 101(g)(3)).”

15 (b) EFFECTIVE DATE.—The amendments made by  
 16 this section shall take effect on January 1, 1995.

## 17 **Subtitle C—Credit for Personal** 18 **Assistance**

### 19 **SEC. 421. CREDIT FOR COST OF PERSONAL ASSISTANCE** 20 **SERVICES REQUIRED BY EMPLOYED INDIVID-** 21 **UALS.**

22 (a) IN GENERAL.—Subpart A of part IV of sub-  
 23 chapter A of chapter 1 (relating to nonrefundable personal  
 24 credits) is amended by inserting after section 23 the fol-  
 25 lowing new section:

1 **“SEC. 24. COST OF PERSONAL ASSISTANCE SERVICES RE-**  
2 **QUIRED BY EMPLOYED INDIVIDUALS.**

3 “(a) ALLOWANCE OF CREDIT.—

4 “(1) IN GENERAL.—In the case of an eligible  
5 individual, there shall be allowed as a credit against  
6 the tax imposed by this chapter for the taxable year  
7 an amount equal to the applicable percentage of the  
8 personal assistance expenses paid or incurred by the  
9 taxpayer during such taxable year.

10 “(2) APPLICABLE PERCENTAGE.—For purposes  
11 of paragraph (1), the term ‘applicable percentage’  
12 means 50 percent reduced (but not below zero) by  
13 10 percentage points for each \$5,000 by which the  
14 modified adjusted gross income (as defined in sec-  
15 tion 59B(d)(2)) of the taxpayer for the taxable year  
16 exceeds \$45,000. In the case of a married individual  
17 filing a separate return, the preceding sentence shall  
18 be applied by substituting ‘\$2,500’ for ‘\$5,000’ and  
19 ‘\$22,500’ for ‘\$45,000’.

20 “(b) LIMITATION.—The amount of personal assist-  
21 ance expenses for the benefit of an individual which may  
22 be taken into account under subsection (a) for the taxable  
23 year shall not exceed the lesser of—

24 “(1) \$15,000, or

25 “(2) such individual’s earned income (as de-  
26 fined in section 32(c)(2)) for the taxable year.

1 In the case of a joint return, the amount under the preced-  
2 ing sentence shall be determined separately for each  
3 spouse.

4 “(c) ELIGIBLE INDIVIDUAL.—For purposes of this  
5 section, the term ‘eligible individual’ means any individual  
6 (other than a nonresident alien) who, by reason of any  
7 medically determinable physical impairment which can be  
8 expected to result in death or which has lasted or can be  
9 expected to last for a continuous period of not less than  
10 12 months, is unable to engage in any substantial gainful  
11 employment activity without personal assistance services  
12 appropriate to carry out activities of daily living. An indi-  
13 vidual shall not be treated as an eligible individual unless  
14 such individual furnishes such proof thereof (in such form  
15 and manner, and at such times) as the Secretary may re-  
16 quire.

17 “(d) OTHER DEFINITIONS.—For purposes of this  
18 section—

19 “(1) PERSONAL ASSISTANCE EXPENSES.—The  
20 term ‘personal assistance expenses’ means expenses  
21 for—

22 “(A) personal assistance services appro-  
23 priate to carry out activities of daily living in or  
24 outside the home,

1           “(B) homemaker/chore services incidental  
2           to the provision of such personal assistance  
3           services,

4           “(C) communication services,

5           “(D) work-related support services,

6           “(E) coordination of services described in  
7           this paragraph,

8           “(F) technology and devices necessary to  
9           assist an individual in carrying out the activi-  
10          ties of daily living or gainful employment activi-  
11          ties, including assessment of the need for par-  
12          ticular technology and devices and training of  
13          family members, and

14          “(G) modifications to the principal place of  
15          abode of the individual to the extent the ex-  
16          penses for such modifications would (but for  
17          subsection (e)(2)) be expenses for medical care  
18          (as defined by section 213) of such individual.

19          “(2) ACTIVITIES OF DAILY LIVING.—The term  
20          ‘activities of daily living’ means eating, toileting,  
21          transferring, bathing, and dressing.

22          “(e) SPECIAL RULES.—

23          “(1) PAYMENTS TO RELATED PERSONS.—No  
24          credit shall be allowed under this section for any  
25          amount paid by the taxpayer to any person who is



1 related (within the meaning of section 267 or  
2 707(b)) to the taxpayer.

3 “(2) COORDINATION WITH MEDICAL EXPENSE  
4 DEDUCTION.—Any amount taken into account in de-  
5 termining the credit under this section shall not be  
6 taken into account in determining the amount of the  
7 deduction under section 213.

8 “(3) BASIS REDUCTION.—For purposes of this  
9 subtitle, if a credit is allowed under this section for  
10 any expense with respect to any property, the in-  
11 crease in the basis of such property which would  
12 (but for this paragraph) result from such expense  
13 shall be reduced by the amount of the credit so al-  
14 lowed.

15 “(f) COST-OF-LIVING ADJUSTMENT.—In the case of  
16 any taxable year beginning after 1996, the \$45,000 and  
17 \$22,500 amounts in subsection (a)(2) and the \$15,000  
18 amount in subsection (b) shall be increased by an amount  
19 equal to—

20 “(1) such dollar amount, multiplied by

21 “(2) the cost-of-living adjustment determined  
22 under section 1(f)(3) for the calendar year in which  
23 the taxable year begins by substituting ‘calendar  
24 year 1995’ for ‘calendar year 1992’ in subparagraph  
25 (B) thereof.

1 If any increase determined under the preceding sentence  
2 is not a multiple of \$1,000, such increase shall be rounded  
3 to the nearest multiple of \$1,000.”

4 (b) TECHNICAL AMENDMENT.—Subsection (a) of  
5 section 1016 is amended by striking “and” at the end of  
6 paragraph (24), by striking the period at the end of para-  
7 graph (25) and inserting “, and”, and by adding at the  
8 end thereof the following new paragraph:

9 “(26) in the case of any property with respect  
10 to which a credit has been allowed under section 24,  
11 to the extent provided in section 24(e)(3).”

12 (c) CLERICAL AMENDMENT.—The table of sections  
13 for subpart A of part IV of subchapter A of chapter 1  
14 is amended by inserting after the item relating to section  
15 23 the following new item:

“Sec. 24. Cost of personal assistance services required by em-  
ployed individuals.”

16 (d) EFFECTIVE DATE.—The amendments made by  
17 this section shall apply to taxable years beginning after  
18 December 31, 1995.

**TITLE V—HEALTH CARE  
PROVIDERS  
Subtitle A—Education and  
Research**

**SEC. 501. ADVISORY COMMISSION ON WORKFORCE.**

(a) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

“(j) ADVISORY COMMISSION ON WORK FORCE.—

“(1) ESTABLISHMENT.—The Director of the Congressional Office of Technology Assessment (in this subsection referred to as the ‘Director’ and the ‘Office’, respectively) shall provide for the appointment of an Advisory Commission on Workforce (in this subsection referred to as the ‘Advisory Commission’) without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

“(2) MEMBERSHIP.—

“(A) COMPOSITION.—The Commission shall consist of 17 individuals with expertise in medical education, the operation of teaching hospitals, the operation of health plans, and other interested individuals.

1           “(B) TERMS.—Members of the Commis-  
2           sion shall first be appointed by no later than  
3           October 1, 1995, for a term of 3 years, except  
4           that the Director may provide initially for such  
5           shorter terms as will ensure that (on a continu-  
6           ing basis) the terms of no more than 4 mem-  
7           bers expire in any 1 year.

8           “(C) CHAIR AND VICE CHAIR.—The Com-  
9           mission shall select a Chair and Vice Chair  
10          from among its members.

11          “(3) MEETINGS.—

12               “(A) IN GENERAL.—The Commission shall  
13               meet at the call of the Chair.

14               “(B) INITIAL MEETING.—No later than 30  
15               days after the date on which all members of the  
16               Commission have been appointed, the Commis-  
17               sion shall hold its first meeting.

18               “(C) QUORUM.—A majority of the mem-  
19               bers of the Commission shall constitute a  
20               quorum, but a lesser number of members may  
21               hold hearings.

22          “(4) DUTIES OF THE COMMISSION.—

23               “(A) IN GENERAL.—The Commission shall  
24               not later than October 1, 1996, submit to the  
25               Committee on Finance and the Committee on

1 Labor and Human Resources of the Senate and  
2 the Committee on Ways and Means, the Com-  
3 mittee on Education and Labor, and the Com-  
4 mittee on Energy and Commerce of the House  
5 of Representatives a report on national health  
6 care workforce policy and payment that in-  
7 cludes—

8 “(i) assessments and recommenda-  
9 tions, as appropriate, in the following  
10 areas:

11 “(I) The composition of the phy-  
12 sician and non-physician national  
13 health care workforce and how such  
14 composition addresses the needs of  
15 the health care market.

16 “(II) Sources and uses of funds  
17 related to graduate medical education  
18 and options for future payment policy.

19 (III) Current payment distribu-  
20 tion methods related to graduate med-  
21 ical education and options for future  
22 distribution policy.

23 “(IV) Current incentives to en-  
24 courage health care practitioners to  
25 enter primary health care specialty

1 areas and to provide services in un-  
2 derserved areas and options for future  
3 policies.

4 “(V) Current role, composition,  
5 distribution, and costs related to for-  
6 eign medical graduates in the national  
7 health care workforce and options for  
8 future policies;

9 “(ii) recommendations for a coordi-  
10 nated policy for the future direction and  
11 distribution of grants, demonstration  
12 projects, and other funding affecting the  
13 health care workforce; and

14 (iii) recommendations and a schedule  
15 for topics to be addressed in subsequent  
16 quarterly reports, based on the findings  
17 and recommendations of the Commission  
18 described in the previous clauses.

19 “(5) CONSULTATION.—The Commission shall  
20 develop its recommendations and assessments under  
21 this subsection in consultation with the Physician  
22 Payment Review Commission, the Prospective Pay-  
23 ment Assessment Commission, and private expert  
24 entities as appropriate.

1           “(6) CERTAIN PROVISIONS APPLICABLE.—Sec-  
 2           tion 1845(c)(1) shall apply to the Commission in the  
 3           same manner as it applies to the Physician Payment  
 4           Review Commission.

5           “(7) AUTHORIZATION OF APPROPRIATIONS.—In  
 6           addition to any amounts made available by the  
 7           amendment made by subsection (b) of section 501 of  
 8           the America’s Health Care Option Act, there are au-  
 9           thorized to be appropriated such sums as may be  
 10          necessary to carry out the provisions of this sub-  
 11          section.”.

12          (b) CONFORMING AMENDMENT REPEALING THE  
 13          COUNCIL ON GRADUATE MEDICAL EDUCATION.—Effec-  
 14          tive October 1, 1995, section 30 of the Health Professions  
 15          Extension Amendments of 1992 (Public Law 102-408) is  
 16          repealed.

17      **SEC. 502. GRADUATE MEDICAL EDUCATION CONSORTIUM**  
 18                              **DEMONSTRATION PROJECTS.**

19          (a) IN GENERAL.—Section 1886 of the Social Secu-  
 20          rity Act (42 U.S.C. 1395ww), as amended by section 501,  
 21          is amended by adding at the end the following new sub-  
 22          section:

23           “(k) CONSORTIUM DEMONSTRATION PROGRAM.—

24           “(1) IN GENERAL.—The Secretary, in consulta-  
 25          tion with the Advisory Commission on Workforce

1 (established under subsection (j)), shall provide for  
2 the establishment of demonstration projects for no  
3 more than 10 health care training consortia which  
4 are located in a State or are multi-State consortia  
5 for the purpose of testing and evaluating mecha-  
6 nisms to increase the number and percentage of  
7 medical students entering primary care practice rel-  
8 ative to those entering nonprimary care practice  
9 through the use of funds otherwise available for di-  
10 rect graduate medical education costs under sub-  
11 section (h).

12 “(2) APPLICATIONS.—

13 “(A) IN GENERAL.—Each health care  
14 training consortium desiring to conduct a dem-  
15 onstration project under this subsection shall  
16 prepare and submit to the Secretary an applica-  
17 tion, at such time, in such manner, and con-  
18 taining such information as the Secretary may  
19 require, including an explanation of a plan for  
20 evaluating the project.

21 “(B) APPROVAL OF APPLICATIONS.—A  
22 consortium that submits an application under  
23 subparagraph (A) may begin a demonstration  
24 project under this subsection—



1           “(i) upon approval of such application  
2           by the Secretary; or

3           “(ii) at the end of the 60-day period  
4           beginning on the date such application is  
5           submitted, unless the Secretary denies the  
6           application during such period.

7           “(3)     FUNDING     FOR     DEMONSTRATION  
8     PROJECTS.—

9           “(A) ALLOCATION OF GME FUNDS.—

10          “(i) IN GENERAL.—For each year a  
11          consortium conducts a demonstration  
12          project under this subsection the Secretary  
13          shall pay to such consortium an amount  
14          equal to the total amount available to hos-  
15          pitals that are members of the consortium  
16          under subsection (h). The consortium shall  
17          designate a teaching hospital for each resi-  
18          dent assigned to the consortium which the  
19          Secretary shall use to calculate the consor-  
20          tium’s payment amount under such sec-  
21          tion. Such teaching hospital shall be the  
22          hospital where the resident receives the  
23          majority of the resident’s hospital-based,  
24          nonambulatory training experience.

1           “(ii) ADDITIONAL INCENTIVE PAY-  
2           MENT.—For each year a consortium con-  
3           ducts a demonstration project under this  
4           subsection the Secretary shall also pay to  
5           selected consortium an amount equal to an  
6           incentive amount according to a formula to  
7           be determined by the Secretary that would  
8           allocate the amount made available pursu-  
9           ant to subsection (d)(5)(B)(v) in such year  
10          among the consortia conducting a dem-  
11          onstration project under this subsection.

12          “(iii) USE OF FUNDS.—

13               “(I) TESTING AND EVALUA-  
14               TION.—Each consortium that receives  
15               a payment under clause (i) shall use  
16               such funds to conduct activities which  
17               test and evaluate mechanisms to in-  
18               crease the number and percentage of  
19               medical students entering primary  
20               care practice relative to those entering  
21               nonprimary care practice.

22               “(II) ESTABLISHMENT AND OP-  
23               ERATION.—Each consortium that re-  
24               ceives a payment under clause (i) may  
25               also use such funds for the establish-

1                   ment and operation of the consortium.  
2                   The Secretary shall make payments to  
3                   the consortium through an entity  
4                   identified by the consortium as appro-  
5                   priate for receiving payment on behalf  
6                   of the consortium. The consortium  
7                   shall have discretion in determining  
8                   the purposes for which such payments  
9                   may be used.

10                   “(B) GRANTS FOR PLANNING AND EVAL-  
11                   UATIONS.—

12                   “(i) IN GENERAL.—The Secretary  
13                   may award grants to consortia conducting  
14                   demonstration projects under this sub-  
15                   section for the purpose of developing and  
16                   evaluating such projects. Each consortium  
17                   desiring to receive a grant under this sub-  
18                   paragraph shall prepare and submit to the  
19                   Secretary an application, at such time, in  
20                   such manner, and containing such infor-  
21                   mation as the Secretary may require.

22                   “(ii) AUTHORIZATION OF APPROPRIA-  
23                   TIONS.—There are authorized to be appro-  
24                   priated such sums as may be necessary to

1           carry out the purposes of this subpara-  
2           graph for fiscal years 1995 through 2003.

3           “(4) MAINTENANCE OF EFFORT.—Any funds  
4           available for the activities covered by a demonstra-  
5           tion project conducted under this subsection shall  
6           supplement, and shall not supplant, funds that are  
7           expended for similar purposes under any State, re-  
8           gional, or local program.

9           “(5) DURATION.—A demonstration project  
10          under this subsection shall be conducted for a period  
11          not to exceed 8 years. The Secretary may terminate  
12          a project if the Secretary determines that the con-  
13          sortium conducting the project is not in substantial  
14          compliance with the terms of the application ap-  
15          proved by the Secretary under this subsection.

16          “(6) EVALUATIONS AND REPORTS.—

17               “(A) EVALUATIONS.—Each consortium  
18               that conducts a demonstration project under  
19               this subsection shall submit to the Secretary  
20               and the Advisory Commission on Workforce a  
21               final evaluation of such project within 360 days  
22               of the termination of such project and such in-  
23               terim evaluations as the Secretary may require.

24               “(B) REPORTS TO CONGRESS.—Not later  
25               than 360 days after the first demonstration

1 project under this subsection begins, and annu-  
2 ally thereafter for each year in which a project  
3 is conducted under this subsection, the Sec-  
4 retary shall submit a report to the appropriate  
5 committees of the Congress which evaluates the  
6 effectiveness of the demonstration projects con-  
7 ducted under this subsection and includes any  
8 legislative recommendations determined appro-  
9 priate by the Secretary.

10 “(7) DEFINITIONS.—For purposes of this sub-  
11 section:

12 “(A) AMBULATORY TRAINING SITES.—The  
13 term ‘ambulatory training sites’ includes, but is  
14 not limited to, health maintenance organiza-  
15 tions, federally qualified health centers, commu-  
16 nity health centers, migrant health centers,  
17 rural health clinics, nursing homes, hospice, and  
18 other community-based providers, including pri-  
19 vate practices.

20 “(B) HEALTH CARE TRAINING CONSOR-  
21 TIUM.—The term ‘health care training consor-  
22 tium’ includes a State, regional, or local entity  
23 which—

24 “(i) includes, but is not limited to  
25 partnerships of teaching hospitals, ambula-

1 tory training sites, and one or more schools  
2 of medicine; and

3 “(ii) is operated in a manner intended  
4 to ensure that by the end of the 8-year  
5 demonstration project there will be an in-  
6 crease in the number and percentage of  
7 medical school students entering primary  
8 care practice relative to those entering  
9 nonprimary care practice.

10 “(C) PRIMARY CARE.—The term ‘primary  
11 care’ means family practice, general internal  
12 medicine, and general pediatrics, and obstetrics  
13 and gynecology.”.

14 (b) SOURCE OF INCENTIVE PAYMENTS.—Section  
15 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amended  
16 by adding at the end the following new clause:

17 “(v) For the purpose of making payments pur-  
18 suant to subsection (k)(3)(A)(ii) for fiscal years  
19 1996, 1997, 1998, 1999, and 2000, there shall be  
20 available from the Federal Hospital Insurance Trust  
21 Fund \$200,000,000 of the amount that would have  
22 been expended under this subparagraph if the  
23 amendments made by section 816 of the America’s  
24 Health Care Option Act had not been in effect.”.

1 **SEC. 503. FUNDING UNDER MEDICARE FOR TRAINING IN**  
 2 **NONHOSPITAL-OWNED FACILITIES.**

3 (a) RESIDENCY TRAINING TIME IN NONHOSPITAL-  
 4 OWNED FACILITIES COUNTED IN DETERMINING FULL-  
 5 TIME-EQUIVALENT RESIDENTS FOR DIRECT GRADUATE  
 6 MEDICAL EDUCATION PAYMENTS.—Section  
 7 1886(h)(4)(E) of the Social Security Act (42 U.S.C.  
 8 1395ww(h)(4)(E)) is amended by striking “, if the hos-  
 9 pital incurs all, or substantially all, of the costs for the  
 10 training program in that setting”.

11 (b) RESIDENCY TRAINING TIME IN NONHOSPITAL-  
 12 OWNED FACILITIES COUNTED IN DETERMINING FULL-  
 13 TIME-EQUIVALENT RESIDENTS FOR INDIRECT MEDICAL  
 14 EDUCATION PAYMENTS.—

15 (1) IN GENERAL.—Section 1886(d)(5)(B)(iv) of  
 16 the Social Security Act (42 U.S.C.  
 17 1395ww(d)(5)(B)(iv)) is amended to read as follows:

18 “(iv) In determining such adjustment,  
 19 the Secretary shall—

20 “(I) count interns and residents  
 21 assigned to any patient service envi-  
 22 ronment which is part of the hos-  
 23 pital’s approved medical residency  
 24 training program (as defined in sub-  
 25 section (h)(5)(A)); and

1                   “(II) count interns and residents  
2                   providing services at any entity receiv-  
3                   ing a grant under section 330 of the  
4                   Public Health Service Act that is  
5                   under the ownership or control of a  
6                   hospital (if the hospital incurs all, or  
7                   substantially all, of the costs of the  
8                   services furnished by such interns and  
9                   residents),  
10                  as part of the calculation of the full-time-  
11                  equivalent number of interns and resi-  
12                  dents.”.

13               (2) ADJUSTMENT OF INDIRECT TEACHING AD-  
14               JUSTMENT FACTOR TO ACHIEVE BUDGET NEUTRAL-  
15               ITY.—Section 1886(d)(5)(B) of the Social Security  
16               Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by  
17               adding at the end the following new clause:

18               “(vi) The Secretary shall reduce all payments  
19               under this subparagraph by such percentage as the  
20               Secretary determines necessary so that, beginning on  
21               the date of the enactment of the America’s Health  
22               Care Option Act, the amendments made by section  
23               503(b)(1) of such Act would not result in expendi-  
24               tures under this subparagraph that exceed the



1 amount of such expenditures that would have been  
 2 made if such amendments had not been made.”.

3 **SEC. 504. NATIONAL FUND FOR MEDICAL RESEARCH.**

4 (a) DESIGNATION OF OVERPAYMENTS AND CON-  
 5 TRIBUTIONS FOR THE NATIONAL FUND FOR MEDICAL  
 6 RESEARCH.—

7 (1) IN GENERAL.—Subchapter A of chapter 61  
 8 of the Internal Revenue Code of 1986 (relating to  
 9 returns and records) is amended by adding at the  
 10 end the following new part:

11 **“PART IX—DESIGNATION OF OVERPAYMENTS**  
 12 **AND CONTRIBUTIONS FOR THE NATIONAL**  
 13 **FUND FOR MEDICAL RESEARCH**

“Sec. 6097. Amounts for the National Fund for Medical Research.

14 **“SEC. 6097. AMOUNTS FOR THE NATIONAL FUND FOR MEDI-**  
 15 **CAL RESEARCH.**

16 “(a) IN GENERAL.—Every individual (other than a  
 17 nonresident alien) may designate that—

18 “(1) a portion (not less than \$1) of any over-  
 19 payment of the tax imposed by chapter 1 for the  
 20 taxable year, and

21 “(2) a cash contribution (not less than \$1),  
 22 be paid over to the National Fund for Medical Research.  
 23 In the case of a joint return of a husband and wife, each

1 spouse may designate one-half of any such overpayment  
2 of tax (not less than \$2).

3       “(b) MANNER AND TIME OF DESIGNATION.—Any  
4 designation under subsection (a) may be made with re-  
5 spect to any taxable year only at the time of filing the  
6 original return of the tax imposed by chapter 1 for such  
7 taxable year. Such designation shall be made either on the  
8 1st page of the return or on the page bearing the tax-  
9 payer’s signature.

10       “(c) OVERPAYMENTS TREATED AS REFUNDED.—For  
11 purposes of this section, any overpayment of tax des-  
12 ignated under subsection (a) shall be treated as being re-  
13 funded to the taxpayer as of the last day prescribed for  
14 filing the return of tax imposed by chapter 1 (determined  
15 with regard to extensions) or, if later, the date the return  
16 is filed.

17       “(d) DESIGNATED AMOUNTS NOT DEDUCTIBLE.—  
18 No deduction shall be allowed under subtitle A with re-  
19 spect to any amount designated pursuant to subsection (a)  
20 for any taxable year.

21       “(e) TERMINATION.—This section shall not apply to  
22 taxable years beginning in a calendar year after a deter-  
23 mination by the Secretary that the sum of all designations  
24 under subsection (a) for taxable years beginning in the

1 second and third calendar years preceding the calendar  
2 year is less than \$5,000,000.”.

3 (2) CLERICAL AMENDMENT.—The table of  
4 parts for subchapter A of chapter 61 of such Code  
5 is amended by adding at the end the following new  
6 item:

“Part IX. Designation of overpayments and contributions for the  
National Fund for Medical Research.”.

7 (3) EFFECTIVE DATE.—The amendments made  
8 by this subsection shall apply to taxable years begin-  
9 ning after December 31, 1994.

10 (b) ESTABLISHMENT OF THE NATIONAL FUND FOR  
11 MEDICAL RESEARCH.—

12 (1) IN GENERAL.—Subchapter A of chapter 98  
13 of the Internal Revenue Code of 1986 (relating to  
14 the trust fund code) is amended by adding at the  
15 end the following new section:

16 **“SEC. 9512. NATIONAL FUND FOR MEDICAL RESEARCH.**

17 “(a) CREATION OF FUND.—There is established in  
18 the Treasury of the United States a fund to be known  
19 as the “National Fund for Medical Research”, consisting  
20 of such amounts as may be credited or paid to such Fund  
21 as provided in this section or section 9602(b).

22 “(b) TRANSFERS TO FUND.—There is hereby trans-  
23 ferred to the National Fund for Medical Research  
24 amounts equivalent to the amounts designated under sec-

1 tion 6097 (relating to designation of overpayments and  
2 contributions to the Fund).

3 “(c) EXPENDITURES FROM FUND.—

4 “(1) IN GENERAL.—The Secretary shall pay an-  
5 nually, within 30 days after the President signs an  
6 appropriations Act for the Departments of labor,  
7 Health and Human Services, and Education, and re-  
8 lated agencies, or by the end of the first quarter of  
9 the fiscal year, to the Secretary of Health and  
10 Human Services on behalf of the National Institutes  
11 of Health, an amount equal to the amount in the  
12 National Fund for Medical Research at the time of  
13 such payment, to carry out the purposes of section  
14 404F of the Public Health Service Act, less any ad-  
15 ministrative expenses which may be paid under para-  
16 graph (2).

17 “(2) ADMINISTRATIVE EXPENSES.—Amounts in  
18 the National Fund for Medical Research shall be  
19 available to pay the administrative expenses of the  
20 Department of the Treasury directly allocable to—

21 “(A) modifying the individual income tax  
22 return forms to carry out section 6097,

23 “(B) carrying out this chapter with respect  
24 to such Fund, and

1           “(C) processing amounts received under  
2           section 6097 and transferring such amounts to  
3           such Fund.

4           “(d) BUDGET TREATMENT OF AMOUNTS IN FUND.—  
5   The amounts in the National Fund for Medical Research  
6   shall be excluded from, and shall not be taken into ac-  
7   count, for purposes of any budget enforcement procedure  
8   under the Congressional Budget Act of 1974 or the Bal-  
9   anced Budget and Emergency Deficit Control Act of  
10  1985.”.

11           (2) CLERICAL AMENDMENT.—The table of sec-  
12   tions for subchapter A of chapter 98 of the Internal  
13   Revenue Code of 1986 is amended by adding at the  
14   end the following new item:

                  “Sec. 9512. National Fund for Medical Research.”.

15           (c) PURPOSES FOR EXPENDITURES FROM FUND.—  
16   Part A of title IV of the Public Health Service Act is  
17   amended by adding at the end the following new section:

18   **“SEC. 404F. EXPENDITURES FROM THE NATIONAL FUND**  
19                   **FOR MEDICAL RESEARCH.**

20           “(a) DISTRIBUTION OF AMOUNTS.—From amounts  
21   received for any fiscal year from the National Fund for  
22   Medical Research, the Secretary shall distribute—

23           “(1) 3 percent of such amounts to the Director  
24   of NIH to be allocated at the Director’s discretion  
25   for—

1           “(A) carrying out the responsibilities of the  
2           Director of NIH, including the Office of Re-  
3           search on Women’s Health, the Office of Re-  
4           search on Minority Health, the Office on Alter-  
5           native Medicine, and the Office of Rare Disease  
6           Research;

7           “(B) construction of, and acquisition of  
8           equipment for, facilities of or used by the Na-  
9           tional Institutes of Health; and

10          “(C) transfer to the National Center for  
11          Research Resources to carry out section 481A  
12          concerning biomedical and behavioral research  
13          facilities;

14          “(2) 1 percent of such amounts for carrying out  
15          section 301 and part D of this title with respect to  
16          health information communications; and

17          “(3) the remainder of such amounts to member  
18          institutes and centers of the National Institutes of  
19          Health in the same proportion to the total amount  
20          received under this subsection, as the amount of an-  
21          nual appropriations under appropriations Acts for  
22          each member institute or center for the fiscal year  
23          bears to the total amount of appropriations under  
24          appropriations Acts for all member institutes and

1        centers of the National Institutes of Health for the  
2        fiscal year.

3        “(b) PLANS OF ALLOCATION.—The amounts trans-  
4        ferred under subsection (a) shall be allocated by the Direc-  
5        tor of NIH or the various directors of the institutes and  
6        centers, as the case may be, pursuant to allocation plans  
7        developed by the various advisory councils to such direc-  
8        tors, after consultation with such directors.

9        “(c) GRANTS AND CONTRACTS FULLY FUNDED IN  
10       FIRST YEAR.—With respect to any grant or contract  
11       funded by amounts distributed under subsection (a), the  
12       full amount of the total obligation of such grant or con-  
13       tract shall be funded in the first year of such grant or  
14       contract, and shall remain available until expended.

15       “(d) MAINTENANCE OF EFFORT.—No amounts  
16       transferred under subsection (a) shall replace or reduce  
17       the amount of appropriations for the National Institutes  
18       of Health under appropriations Acts.”.

## 19       **Subtitle B—Health Care Liability** 20       **Reform**

### 21       **SEC. 511. HEALTH CARE LIABILITY REFORM.**

22       (a) IN GENERAL.—Part A of subtitle A of title XI  
23       of the Social Security Act (42 U.S.C. 1301 et seq.) is  
24       amended by inserting after section 1128B the following  
25       new section:

1 **“SEC. 1129. HEALTH CARE LIABILITY REFORM.**

2 “(a) DEFINITIONS.—As used in this section:

3 “(1) CLAIMANT.—The term ‘claimant’ means  
4 any person who commences a health care liability ac-  
5 tion, and any person on whose behalf such an action  
6 is commenced, including the decedent in the case of  
7 an action brought through or on behalf of an estate.

8 “(2) CLEAR AND CONVINCING EVIDENCE.—The  
9 term ‘clear and convincing evidence’ is that measure  
10 or degree of proof that will produce in the mind of  
11 the trier of fact a firm belief or conviction as to the  
12 truth of the allegations sought to be established, ex-  
13 cept that such measure or degree of proof is more  
14 than that required under preponderance of the evi-  
15 dence, but less than that required for proof beyond  
16 a reasonable doubt.

17 “(3) HEALTH CARE LIABILITY ACTION.—The  
18 term “health care liability action” means a civil ac-  
19 tion in a State or Federal court—

20 “(A) against a health care provider, health  
21 care professional, or other defendant joined in  
22 the action (regardless of the theory of liability  
23 on which the action is based) in which the  
24 claimant alleges injury related to the provision  
25 of, or the failure to provide, health care serv-  
26 ices; or



1           “(B) against a health care payor, a health  
2           maintenance organization, insurance company,  
3           or any other individual, organization, or entity  
4           that provides payment for health care benefits  
5           in which the claimant alleges that injury was  
6           caused by the payment for, or the failure to  
7           make payment for, health care benefits, except  
8           to the extent such actions are subject to the  
9           Employee Retirement Income Security Act of  
10          1974.

11          “(3) HEALTH CARE PROFESSIONAL.—The term  
12          ‘health care professional’ means any individual who  
13          provides health care services in a State and who is  
14          required by Federal or State laws or regulations to  
15          be licensed, registered or certified to provide such  
16          services or who is certified to provide health care  
17          services pursuant to a program of education, train-  
18          ing and examination by an accredited institution,  
19          professional board, or professional organization.

20          “(4) HEALTH CARE PROVIDER.—The term  
21          ‘health care provider’ means any organization or in-  
22          stitution that is engaged in the delivery of health  
23          care services in a State and that is required by Fed-  
24          eral or State laws or regulations to be licensed, reg-

1        istered or certified to engage in the delivery of such  
2        services.

3            “(5) HEALTH CARE SERVICES.—The term  
4        ‘health care services’ means any services provided by  
5        a health care professional or health care provider, or  
6        any individual working under the supervision of a  
7        health care professional, that relate to the diagnosis,  
8        prevention, or treatment of any disease or impair-  
9        ment, or the assessment of the health of human  
10       beings.

11           “(6) INJURY.—The term ‘injury’ means any ill-  
12        ness, disease, or other harm that is the subject of  
13        a health care liability action.

14           “(7) NONECONOMIC LOSSES.—The term ‘non-  
15        economic losses’ means losses for physical and emo-  
16        tional pain, suffering, inconvenience, physical im-  
17        pairment, mental anguish, disfigurement, loss of en-  
18        joyment of life, loss of consortium, and other  
19        nonpecuniary losses incurred by an individual with  
20        respect to which a health care liability action is  
21        brought.

22           “(8) PUNITIVE DAMAGES.—The term ‘punitive  
23        damages’ means damages awarded, for the purpose  
24        of punishment or deterrence, and not for compen-  
25        satory purposes, against a health care provider,

1 health care organization, or other defendant in a  
2 health care liability action. Punitive damages are  
3 neither economic nor noneconomic damages.

4 “(b) APPLICABILITY.—

5 “(1) IN GENERAL.—Except as provided in para-  
6 graph (3), this section shall apply with respect to  
7 any health care liability action brought in any Fed-  
8 eral or State court, except that this section shall not  
9 apply to an action for damages arising from a vac-  
10 cine-related injury or death to the extent that title  
11 XXI of the Public Health Service Act applies to the  
12 action.

13 “(2) PREEMPTION.—The provisions of this sec-  
14 tion shall preempt any State law to the extent such  
15 law is inconsistent with the limitations contained in  
16 such provisions. The provisions of this section shall  
17 not preempt any State law that—

18 “(A) provides for defenses in addition to  
19 those contained in this section, places greater  
20 limitations on the amount of attorneys’ fees  
21 that can be collected, or otherwise imposes  
22 greater restrictions on non-economic or punitive  
23 damages than those provided in this section;

1           “(B) permits State officials to commence  
2 health care liability actions as a representative  
3 of an individual; or

4           “(C) permits provider-based dispute resolu-  
5 tion.

6           “(3) EFFECT ON SOVEREIGN IMMUNITY AND  
7 CHOICE OF LAW OR VENUE.—Nothing in this section  
8 shall be construed to—

9           “(A) waive or affect any defense of sov-  
10 ereign immunity asserted by any State under  
11 any provision of law;

12           “(B) waive or affect any defense of sov-  
13 ereign immunity asserted by the United States;

14           “(C) affect the applicability of any provi-  
15 sion of the Foreign Sovereign Immunities Act  
16 of 1976;

17           “(D) preempt State choice-of-law rules  
18 with respect to actions brought by a foreign na-  
19 tion or a citizen of a foreign nation; or

20           “(E) affect the right of any court to trans-  
21 fer venue or to apply the law of a foreign nation  
22 or to dismiss an action of a foreign nation or  
23 of a citizen of a foreign nation on the ground  
24 of inconvenient forum.

1           “(4) FEDERAL COURT JURISDICTION NOT ES-  
2           TABLISHED ON FEDERAL QUESTION GROUNDS.—  
3           Nothing in this section shall be construed to estab-  
4           lish any jurisdiction in the district courts of the  
5           United States over health care liability actions on  
6           the basis of sections 1331 or 1337 of title 28, Unit-  
7           ed States Code.

8           “(c) STATUTE OF LIMITATIONS.—

9           “(1) IN GENERAL.—Except as provided in para-  
10          graph (2), no health care liability action may be ini-  
11          tiated after the expiration of the 2-year period that  
12          begins on the date on which the alleged injury and  
13          its cause should reasonably have been discovered,  
14          but in no event later than 5 years after the date of  
15          the alleged occurrence of the injury.

16          “(2) EXCEPTION FOR MINORS.—In the case of  
17          an alleged injury suffered by a minor who has not  
18          attained 6 years of age, no health care liability ac-  
19          tion may be initiated after the expiration of the 2-  
20          year period that begins on the date on which the al-  
21          leged injury and its cause should reasonably have  
22          been discovered, but in no event later than 6 years  
23          after the date of the alleged occurrence of the injury  
24          and its cause or the date on which the minor attains  
25          11 years of age, whichever is later.

1       “(d) REFORM OF NONECONOMIC DAMAGES.—

2               “(1) IN GENERAL.—With respect to a health  
3       care liability action brought in any forum, the total  
4       amount of damages that may be awarded to an indi-  
5       vidual and the family members of such individual for  
6       noneconomic losses resulting from an injury alleged  
7       under such action may not exceed \$250,000, regard-  
8       less of the number of health care professionals,  
9       health care providers, and other defendants against  
10      whom the action is brought or the number of actions  
11      brought with respect to the injury. If the jury’s  
12      damage award exceeds such limitation, a reduction  
13      in such award shall be made by the court.

14              “(2) STUDY.—The Secretary, in consultation  
15      with the Attorney General, shall conduct a study to  
16      determine an appropriate schedule with respect to  
17      an increase in the limitation described in paragraph  
18      (1) in years subsequent to the calendar year in  
19      which this section is enacted. Not later than Janu-  
20      ary 1, 1997, the Secretary shall submit such a  
21      schedule to Congress.

22              “(3) JOINT RESOLUTION AND CONSIDERATION  
23      BY CONGRESS.—

24              “(A) IN GENERAL.—The schedule under  
25      paragraph (2) shall be implemented unless a

1 joint resolution (described in subparagraph (B))  
2 disapproving such recommendations is enacted  
3 in accordance with the provisions of subpara-  
4 graph (C), before the end of the 45-day period  
5 beginning on the date on which such schedule  
6 was submitted. For purposes of applying the  
7 preceding sentence and subparagraphs (B) and  
8 (C), the days on which either House of Con-  
9 gress is not in session because of an adjourn-  
10 ment of more than three days to a day certain  
11 shall be excluded in the computation of a pe-  
12 riod.

13 “(B) JOINT RESOLUTION OF DIS-  
14 APPROVAL.—A joint resolution described in this  
15 subparagraph means only a joint resolution  
16 which is introduced within the 10-day period  
17 beginning on the date on which the Secretary  
18 submits the schedule under paragraph (2)  
19 and—

20 “(i) which does not have a preamble;

21 “(ii) the matter after the resolving  
22 clause of which is as follows: “That Con-  
23 gress disapproves the schedule of the Sec-  
24 retary of Health and Human Services con-  
25 cerning adjustments in limitations on non-

1 economic damages with respect to health  
2 care liability actions, as submitted by the  
3 Secretary on \_\_\_\_\_.”, the blank  
4 space being filled in with the appropriate  
5 date; and

6 “(iii) the title of which is as follows:  
7 “Joint resolution disapproving the schedule  
8 of the Secretary of Health and Human  
9 Services concerning adjustments in limita-  
10 tions on noneconomic damages with re-  
11 spect to health care liability actions, as  
12 submitted by the Secretary on  
13 \_\_\_\_\_.”, the blank space being  
14 filled in with the appropriate date.

15 “(C) PROCEDURES FOR CONSIDERATION  
16 OF RESOLUTION OF DISAPPROVAL.—Subject to  
17 subparagraph (D), the provisions of section  
18 2908 (other than subsection (a)) of the Defense  
19 Base Closure and Realignment Act of 1990  
20 shall apply to the consideration of a joint reso-  
21 lution described in subparagraph (B) in the  
22 same manner as such provisions apply to a joint  
23 resolution described in section 2908(a) of such  
24 Act.



1           “(D) SPECIAL RULES.—For purposes of  
2           applying subparagraph (C) with respect to such  
3           provisions—

4                   “(i) any reference to the Committee  
5                   on Armed Services of the House of Rep-  
6                   resentatives shall be deemed a reference to  
7                   an appropriate Committee of the House of  
8                   Representatives (specified by the Speaker  
9                   of the House of Representatives at the  
10                  time of submission of recommendations  
11                  under paragraph (1)) and any reference to  
12                  the Committee on Armed Services of the  
13                  Senate shall be deemed a reference to an  
14                  appropriate Committee of the Senate  
15                  (specified by the Majority Leader of the  
16                  Senate at the time of submission of rec-  
17                  ommendations under paragraph (1)); and

18                   “(ii) any reference to the date on  
19                   which the President transmits a report  
20                   shall be deemed a reference to the date on  
21                   which the Secretary submits a rec-  
22                   ommendation under paragraph (1).

23           “(e) REFORM OF PUNITIVE DAMAGES.—

24                   “(1) LIMITATION.—With respect to a health  
25                   care liability action, an award for punitive damages

1 may only be made, if otherwise permitted by applica-  
2 ble law, if it is proven by clear and convincing evi-  
3 dence—

4 “(A) that the defendant intended to injure  
5 the claimant for a reason unrelated to the pro-  
6 vision of health care services;

7 “(B) that the defendant understood the  
8 claimant was substantially certain to suffer un-  
9 necessary injury, yet the defendant in providing  
10 or failing to provide health care services, delib-  
11 erately failed to avoid such injury; or

12 “(C) that the defendant acted with a con-  
13 scious disregard of a substantial and unjustifi-  
14 able risk of unnecessary injury which the de-  
15 fendant failed to avoid in a manner which con-  
16 stitutes a gross deviation from the normal  
17 standard of conduct in such circumstances.

18 “(2) PUNITIVE DAMAGES NOT PERMITTED.—  
19 Notwithstanding the provisions of paragraph (1),  
20 punitive damages may not be awarded against a de-  
21 fendant with respect to any health care liability ac-  
22 tion if—

23 “(A) no judgment for compensatory dam-  
24 ages, including nominal damages (under \$500),  
25 is rendered against the defendant; or

1           “(B) the underlying health care liability  
2           action arises out of the same act or course of  
3           conduct by the defendant that resulted in a  
4           prior award of punitive damages to any individ-  
5           ual.

6           “(3) REQUIREMENTS FOR PLEADING OF PUNI-  
7           TIVE DAMAGES.—

8           “(A) IN GENERAL.—The claimant’s com-  
9           plaint or initial pleading in any health care li-  
10          ability action may not include a demand for pu-  
11          nitive damages.

12          “(B) AMENDED PLEADING.—A court may  
13          allow a claimant to file an amended complaint  
14          or pleading for punitive damages if—

15               “(i) the claimant submits a motion to  
16               amend the complaint or pleading within  
17               the earlier of—

18                       “(I) 2 years after the complaint  
19                       or initial pleading is filed, or

20                       “(II) 9 months before the date  
21                       the matter is first set for trial; and

22               “(ii) after a finding by a court upon  
23               review of supporting and opposing affida-  
24               vits or after a hearing, that after weighing  
25               the evidence the claimant has established

1 by a substantial probability that the claim-  
2 ant will prevail on the claim for punitive  
3 damages.

4 “(4) SEPARATE PROCEEDING.—

5 “(A) IN GENERAL.—At the request of any  
6 defendant in a health care liability action, the  
7 trier of fact shall consider in a separate pro-  
8 ceeding—

9 “(i) whether punitive damages are to  
10 be awarded and the amount of such award,  
11 or

12 “(ii) the amount of punitive damages  
13 following a determination of punitive liabil-  
14 ity.

15 “(B) ONLY RELEVANT EVIDENCE ADMISSI-  
16 BLE.—If a defendant requests a separate pro-  
17 ceeding under subparagraph (A), evidence rel-  
18 evant only to the claim of punitive damages, as  
19 determined by applicable State law, shall be in-  
20 admissible in any proceeding to determine  
21 whether compensatory damages are to be  
22 awarded.

23 “(5) DETERMINING AMOUNT OF PUNITIVE DAM-  
24 AGES.—

1           “(A) IN GENERAL.—In determining the  
2           amount of punitive damages, the trier of fact  
3           shall consider only the following:

4                   “(i) The severity of the harm caused  
5                   by the conduct of the defendant.

6                   “(ii) The duration of the conduct or  
7                   any concealment of it by the defendant.

8                   “(iii) The profitability of the conduct  
9                   of the defendant.

10                  “(iv) The number of products sold or  
11                  medical procedures rendered for compensa-  
12                  tion, as the case may be, by the defendant  
13                  of the kind causing the harm complained  
14                  of by the claimant.

15                  “(v) Awards of punitive or exemplary  
16                  damages to persons similarly situated to  
17                  the claimant, when offered by the defend-  
18                  ant.

19                  “(vi) Prospective awards of compen-  
20                  satory damages to persons similarly situ-  
21                  ated to the claimant.

22                  “(vii) Any criminal penalties imposed  
23                  on the defendant as a result of the conduct  
24                  complained of by the claimant, when of-  
25                  fered by the defendant.

1           “(viii) The amount of any civil fines  
2           assessed against the defendant as a result  
3           of the conduct complained of by the claim-  
4           ant, when offered by the defendant.

5           “(B) LIMITATION ON AMOUNT OF PUNI-  
6           TIVE DAMAGES.—In no event shall the amount  
7           of punitive damages awarded exceed the lesser  
8           of 2 times the amount of compensatory dam-  
9           ages awarded or \$500,000. The jury shall not  
10          be informed of this limitation.

11          “(6) RESTRICTIONS PERMITTED.—Nothing in  
12          this section shall be construed to imply a right to  
13          seek punitive damages where none exists under Fed-  
14          eral or State law.

15          “(7) HEALTH CARE QUALITY ASSURANCE PRO-  
16          GRAM.—

17                 “(A) FUND.—Each participating State  
18                 shall establish a health care quality assurance  
19                 program, to be approved by the Secretary, and  
20                 a fund consisting of such amounts as are trans-  
21                 ferred to the fund under subparagraph (B).

22                 “(B) TRANSFER OF AMOUNTS.—Each par-  
23                 ticipating State shall require that 50 percent of  
24                 all awards of punitive damages resulting from  
25                 all health care liability actions in that State be

1 transferred to the fund established under sub-  
2 paragraph (B) in the State.

3 “(C) OBLIGATIONS FROM FUND.—The  
4 chief executive officer of a participating State  
5 shall obligate such sums as are available in the  
6 fund established in that State under subpara-  
7 graph (A) to—

8 “(A) license and certify health care profes-  
9 sionals in the State;

10 “(B) implement health care quality assur-  
11 ance programs; and

12 “(C) carry out programs to reduce mal-  
13 practice-related costs for health care providers  
14 volunteering to provide health care services in  
15 medically underserved areas.

16 “(f) PERIODIC PAYMENTS.—With respect to a health  
17 care liability action, no person may be required to pay  
18 more than \$100,000 for future damages in a single pay-  
19 ment of a damages award, but a person shall be permitted  
20 to make such payments of the award on a periodic basis.  
21 The periods for such payments shall be determined by the  
22 adjudicating body, based upon projections of future losses  
23 and shall be reduced to present value. The adjudicating  
24 body may waive the requirements of this subsection if such

1 body determines that such a waiver is in the interests of  
2 justice.

3 “(g) SCOPE OF LIABILITY.—

4 “(1) IN GENERAL.—With respect to punitive  
5 and noneconomic damages, the liability of each de-  
6 fendant in a health care liability action shall be sev-  
7 eral only and may not be joint. Such a defendant  
8 shall be liable only for the amount of punitive or  
9 noneconomic damages allocated to the defendant in  
10 direct proportion to such defendant’s percentage of  
11 fault or responsibility for the injury suffered by the  
12 claimant.

13 “(2) DETERMINATION OF PERCENTAGE OF LI-  
14 ABILITY.—The trier of fact in a health care liability  
15 action shall determine the extent of each defendant’s  
16 fault or responsibility for injury suffered by the  
17 claimant, and shall assign a percentage of respon-  
18 sibility for such injury to each such defendant.

19 “(3) PROHIBITION ON VICARIOUS LIABILITY.—  
20 A defendant in a health care liability action may not  
21 be held vicariously liable for the direct actions or  
22 omissions of other individuals.

23 “(h) MANDATORY OFFSETS FOR DAMAGES PAID BY  
24 A COLLATERAL SOURCE.—



1           “(1) IN GENERAL.—With respect to a health  
2       care liability action, the total amount of damages re-  
3       ceived by an individual under such action shall be  
4       reduced, in accordance with paragraph (2), by any  
5       other payment that has been, or will be, made to an  
6       individual to compensate such individual for the in-  
7       jury that was the subject of such action.

8           “(2) AMOUNT OF REDUCTION.—The amount by  
9       which an award of damages to an individual for an  
10      injury shall be reduced under paragraph (1) shall  
11      be—

12           “(A) the total amount of any payments  
13           (other than such award) that have been made  
14           or that will be made to such individual to pay  
15           costs of or compensate such individual for the  
16           injury that was the subject of the action; minus

17           “(B) the amount paid by such individual  
18           (or by the spouse, parent, or legal guardian of  
19           such individual) to secure the payments de-  
20           scribed in subparagraph (A) and any portion of  
21           the award subject to a subrogation lien or  
22           claim.

23           “(i) TREATMENT OF ATTORNEYS’ FEES AND OTHER  
24      COSTS.—

1           “(1) LIMITATION ON AMOUNT OF CONTINGENCY  
2 FEES.—

3           “(A) IN GENERAL.—An attorney who rep-  
4 represents, on a contingency fee basis, a claimant  
5 in a health care liability action may not charge,  
6 demand, receive, or collect for services rendered  
7 in connection with such action in excess of the  
8 following amount recovered by judgment or set-  
9 tlement under such action:

10                   “(i)  $33\frac{1}{3}$  percent of the first  
11 \$150,000 (or portion thereof) recovered,  
12 based on after-tax recovery, plus

13                   “(ii) 25 percent of any amount in ex-  
14 cess of \$150,000 recovered, based on after-  
15 tax recovery.

16           “(B) CALCULATION OF PERIODIC PAY-  
17 MENTS.—In the event that a judgment or set-  
18 tlement includes periodic or future payments of  
19 damages, the amount recovered for purposes of  
20 computing the limitation on the contingency fee  
21 under subparagraph (A) shall be based on the  
22 cost of the annuity or trust established to make  
23 the payments. In any case in which an annuity  
24 or trust is not established to make such pay-

1           ments, such amount shall be based on the  
2           present value of the payments.

3           “(3) CONTINGENCY FEE DEFINED.—As used in  
4           this subsection, the term ‘contingency fee’ means  
5           any fee for professional legal services which is, in  
6           whole or in part, contingent upon the recovery of  
7           any amount of damages, whether through judgment  
8           or settlement.

9           “(j) OBSTETRIC CASES.—With respect to a health  
10          care liability action relating to services provided during  
11          labor or the delivery of a baby, if the health care profes-  
12          sional against whom the action is brought did not pre-  
13          viously treat the pregnant woman for the pregnancy, the  
14          trier of fact may not find that the defendant committed  
15          malpractice and may not assess damages against the  
16          health care professional unless the malpractice is proven  
17          by clear and convincing evidence.

18          “(k) REQUIREMENTS FOR RISK MANAGEMENT PRO-  
19          GRAMS.—

20          “(1) REQUIREMENTS FOR PROVIDERS.—Each  
21          State shall require each health care professional and  
22          health care provider providing services in the State  
23          to participate in a risk management program to pre-  
24          vent and provide early warning of practices which

1       may result in injuries to patients or which otherwise  
2       may endanger patient safety.

3           “(2) REQUIREMENTS FOR INSURERS.—Each  
4       State shall require each entity which provides health  
5       care professional or provider liability insurance to  
6       health care professionals and health care providers  
7       in the State to—

8           “(A) establish risk management programs  
9       based on data available to such entity or sanc-  
10      tion programs of risk management for health  
11      care professionals and health care providers  
12      provided by other entities; and

13          “(B) require each such professional or pro-  
14      vider, as a condition of maintaining insurance,  
15      to participate in one program described in sub-  
16      paragraph (A) at least once in each 3-year pe-  
17      riod.

18      “(l) PERMITTING STATE PROFESSIONAL SOCIETIES  
19      TO PARTICIPATE IN DISCIPLINARY ACTIVITIES.—

20          “(1) ROLE OF PROFESSIONAL SOCIETIES.—  
21      Notwithstanding any other provision of State or  
22      Federal law, a State agency responsible for the con-  
23      duct of disciplinary actions for a type of health care  
24      provider may enter into agreements with State or  
25      county professional societies of such type of health

1 care professional to permit such societies to partici-  
2 pate in the licensing of such health care professional,  
3 and to review any health care liability action, health  
4 care liability allegation, or other information con-  
5 cerning the practice patterns of any such health care  
6 professional. Any such agreement shall comply with  
7 paragraph (2).

8 “(2) REQUIREMENTS OF AGREEMENTS.—Any  
9 agreement entered into under paragraph (1) for li-  
10 censing activities or the review of any health care li-  
11 ability action, health care liability allegation, or  
12 other information concerning the practice patterns  
13 of a health care professional shall provide that—

14 “(A) the health care professional society  
15 conducts such activities or review as expedi-  
16 tiously as possible;

17 “(B) after the completion of such review,  
18 such society shall report its findings to the  
19 State agency with which it entered into such  
20 agreement;

21 “(C) the conduct of such activities or re-  
22 view and the reporting of such findings be con-  
23 ducted in a manner which assures the preserva-  
24 tion of confidentiality of health care information  
25 and of the review process; and

1           “(D) no individual affiliated with such so-  
 2           ciety is liable for any damages or injury directly  
 3           caused by the individual’s actions in conducting  
 4           such activities or review.

5           “(3) AGREEMENTS NOT MANDATORY.—Nothing  
 6           in this subsection may be construed to require a  
 7           State to enter into agreements with societies de-  
 8           scribed in paragraph (1) to conduct the activities de-  
 9           scribed in such paragraph.

10          “(4) EFFECT OF AGREEMENT.—

11          (b) EFFECTIVE DATE.—The amendment made by  
 12          subsection (a) shall apply to health care liability actions  
 13          arising on or after January 1, 1995.

14          **Subtitle C—Health Care Antitrust**  
 15                               **Improvements**

16          **SEC. 521. PROTECTION FROM ANTITRUST LAWS FOR CER-**  
 17                               **TAIN COMPETITIVE AND COLLABORATIVE**  
 18                               **ACTIVITIES.**

19          (a) PROTECTIONS DESCRIBED.—An activity relating  
 20          to the provision of health care services shall receive the  
 21          following protection from the antitrust laws:

22               (1) If the activity is within a safe harbor des-  
 23               ignated by the Attorney General under section 522,  
 24               the safe harbor shall be a defense to all antitrust  
 25               claims, except for claims for injunctive relief as-

1       serted by the Attorney General or the Chair in ex-  
2       traordinary circumstances.

3           (2) If the activity is specified in and in compli-  
4       ance with the terms of a certificate of review issued  
5       by the Attorney General under section 523 and the  
6       activity occurs while the certificate is in effect, the  
7       certificate shall be a defense to antitrust claims,  
8       other than claims for injunctive relief.

9       (b) AWARD OF ATTORNEY'S FEES AND COSTS OF  
10     SUIT.—

11           (1) IN GENERAL.—If any person brings an ac-  
12     tion alleging a claim under the antitrust laws and  
13     the activity on which the claim is based is found by  
14     the court to be protected from such laws under sub-  
15     section (a), the court shall, at the conclusion of the  
16     action—

17           (A) award to a substantially prevailing  
18     claimant the cost of suit attributable to such  
19     claim, including a reasonable attorney's fee, or

20           (B) award to a substantially prevailing  
21     party defending against such claim the cost of  
22     such suit attributable to such claim, including  
23     reasonable attorney's fee, if the claim, or the  
24     claimant's conduct during litigation of the

1 claim, was frivolous, unreasonable, without  
2 foundation, or in bad faith.

3 (2) OFFSET IN CASES OF BAD FAITH.—The  
4 court may reduce an award made pursuant to para-  
5 graph (1) in whole or in part by an award in favor  
6 of another party for any part of the cost of suit (in-  
7 cluding a reasonable attorney's fee) attributable to  
8 conduct during the litigation by any prevailing party  
9 that the court finds to be frivolous, unreasonable,  
10 without foundation, or in bad faith.

11 **SEC. 522. DESIGNATION OF SAFE HARBORS.**

12 (a) IN GENERAL.—

13 (1) DESIGNATION BY ATTORNEY GENERAL.—  
14 The Attorney General, in consultation with the Sec-  
15 retary and the Chair, shall develop and designate  
16 pursuant to paragraph (C) safe harbors for purposes  
17 of section 521(a)(1) relating to—

18 (A) each category of activities referred to  
19 in paragraph (2); and

20 (B) such other categories of activities as  
21 the Attorney General may designate in accord-  
22 ance with the process described in this section.

23 (2) REQUIRED CATEGORIES OF ACTIVITIES SUB-  
24 JECT TO SAFE HARBORS.—The categories of activi-  
25 ties referred to in this paragraph are as follows:



1 (A) JOINT PURCHASING OF HEALTH CARE  
2 SERVICES.—Providing the terms under which  
3 consumers of health care services (patients or  
4 others acting on their behalf) may jointly nego-  
5 tiate and purchase health care services.

6 (B) SMALL HOSPITAL MERGERS.—Provid-  
7 ing for small hospitals lawfully to merge under  
8 the antitrust laws without undue delay or re-  
9 view, taking into account the special needs and  
10 circumstances of rural health care markets.

11 (C) NETWORK FORMATION AND OPER-  
12 ATION.—Permitting activities related to the  
13 startup and operation of collaborations between  
14 State-licensed providers through partial or full  
15 integration, including multi-provider networks,  
16 hospital networks, physician-hospital organiza-  
17 tions, and other efforts to provide health care  
18 services more efficiently.

19 (D) ACTIVITIES OF MEDICAL SELF-REGU-  
20 LATORY ENTITIES.—Permitting standard set-  
21 ting and enforcement activities by medical self-  
22 regulatory entities (such as hospital boards and  
23 medical societies) to promote health care qual-  
24 ity, except that a safe harbor under this para-  
25 graph may not provide protection for any activ-

1           ity undertaken for financial gain or for anti-  
2           competitive reasons.

3           (E) PROVISION OF INFORMATION TO BUY-  
4           ERS AND CONSUMERS.—Permitting health care  
5           providers collectively to supply non-price medi-  
6           cal information to buyers and consumers relat-  
7           ing to the type, quality and efficiency of treat-  
8           ment, including joint views on procedures that  
9           should be covered by purchasers and medical  
10          protocols, except that a safe harbor under this  
11          subparagraph may not provide protection for  
12          any collective refusals to deal or collective at-  
13          tempts at coercion.

14          (F) PARTICIPATION IN SURVEYS.—Provid-  
15          ing the terms under which health care providers  
16          may lawfully participate in written surveys of  
17          prices of services, reimbursements received, em-  
18          ployee compensation, and other relevant areas.

19          (G) HIGH-TECHNOLOGY AND TERTIARY  
20          CARE JOINT VENTURES.—Permitting activities  
21          of health care joint ventures to purchase or use  
22          new or existing high technology or costly equip-  
23          ment, or to provide advanced tertiary care serv-  
24          ices.

1 (H) MARKET POWER SCREENS.—Providing  
2 market power screens at appropriate levels  
3 below which combinations of health care provid-  
4 ers are too small to pose a realistic antitrust  
5 threat. There may be different levels for dif-  
6 ferent activities and markets, taking into ac-  
7 count the special needs of rural health care  
8 markets.

9 (I) JOINT PURCHASING ARRANGEMENTS.—  
10 Providing the terms under which health care  
11 providers may make joint purchases of products  
12 and services.

13 (J) GOOD FAITH NEGOTIATIONS.—Provid-  
14 ing the terms under which health care providers  
15 may engage in discussions relating to legitimate  
16 collaborative activities contemplated by the safe  
17 harbors.

18 (b) PROCESS FOR DESIGNATION OF ADDITIONAL  
19 CATEGORIES OF ACTIVITIES.—

20 (1) SOLICITATION OF PROPOSALS.—Not later  
21 than 30 days after the date of the enactment of this  
22 Act, the Attorney General shall publish a notice in  
23 the Federal Register soliciting proposals for safe  
24 harbors.

1           (2) REVIEW OF PROPOSED SAFE HARBORS.—

2           Not later than 180 days after the date of the enact-  
3           ment of this Act, the Attorney General (in consulta-  
4           tion with the Secretary and the Chair) shall review  
5           the proposed safe harbors submitted under para-  
6           graph (1) and include a description of the safe har-  
7           bors in the report under subsection (d).

8           (3) ADDITIONAL SAFE HARBORS.—After sub-  
9           mitting the report under subsection (d), the Attor-  
10          ney General (in consultation with the Secretary and  
11          the Chair) may from time to time add additional  
12          safe harbors in accordance with the procedures de-  
13          scribed in this subsection.

14          (c) EFFECTIVE DATE OF SAFE HARBORS.—

15               (1) PUBLICATION.—Not later than 180 days  
16               after the date of the enactment of this Act, the At-  
17               torney General shall publish in the Federal Register  
18               for public comment the safe harbors proposed for  
19               designation under this section. Not later than 180  
20               days after publishing such proposed safe harbors in  
21               the Federal Register, the Attorney General shall  
22               issue final rules establishing such safe harbors.

23               (2) EFFECTIVE DATE.—The safe harbors estab-  
24               lished under the final rules issued under paragraph

1 (1) shall take effect 90 days after issuance, unless  
2 disapproved by the Congress.

3 (d) REPORT ON PROPOSED SAFE HARBORS.—Not  
4 later than 180 days after the date of the enactment of  
5 this Act, the Attorney General (in consultation with the  
6 Secretary and the Chair) shall submit a report to Congress  
7 describing the proposals from subsections (a) and (b)(1)  
8 to be included in the publication of safe harbors described  
9 in subsection (c)(1) and the proposals from subsection  
10 (b)(1) that are not to be so included, together with expla-  
11 nations therefor.

12 (e) MODIFICATION OR REMOVAL OF SAFE HAR-  
13 BORS.—The Attorney General (in consultation with the  
14 Secretary and the Chair) may modify or remove a safe  
15 harbor following notice and comment upon a determina-  
16 tion that the safe harbor does not meet the criteria of sub-  
17 section (f).

18 (f) CRITERIA FOR SAFE HARBORS.—In establishing  
19 safe harbors under this section, the Attorney General shall  
20 take into account the following:

21 (1) The extent to which a competitive or col-  
22 laborative activity will accomplish any of the follow-  
23 ing:

24 (A) An increase in access to health care  
25 services.

1 (B) The enhancement of the quality of  
2 health care services.

3 (C) The establishment of cost efficiencies  
4 that will be passed on to consumers, including  
5 economies of scale and reduced transaction and  
6 administrative costs.

7 (D) An increase in the ability of health  
8 care facilities to provide services in medically  
9 underserved areas or to medically underserved  
10 populations.

11 (E) An improvement in the utilization of  
12 health care resources or the reduction in the in-  
13 efficient duplication of the use of such re-  
14 sources.

15 (2) Whether the designation of an activity as a  
16 safe harbor will result in the following outcomes:

17 (A) Health plans and other health care in-  
18 surers, consumers of health care services, and  
19 health care providers will be better able to ne-  
20 gotiate payment and service arrangements  
21 which will reduce costs to consumers.

22 (B) Taking into consideration the charac-  
23 teristics of the particular purchasers and pro-  
24 viders involved, competition will not be unduly  
25 restricted.

1 (C) Equally efficient and less restrictive al-  
2 ternatives do not exist to meet the criteria de-  
3 scribed in paragraph (1).

4 (D) The activity will not unreasonably  
5 foreclose competition by denying competitors a  
6 necessary element of competition.

7 **SEC. 523. CERTIFICATES OF REVIEW.**

8 (a) ESTABLISHMENT OF PROGRAM.—In consultation  
9 with the Secretary and the Chair, the Attorney General  
10 shall (not later than 180 days after the date of the enact-  
11 ment of this Act) issue certificates of review in accordance  
12 with this section for providers of health care services and  
13 advise and assist any person with respect to applying for  
14 such a certificate of review.

15 (b) PROCEDURES FOR APPLICATION FOR CERTIFI-  
16 CATE.—

17 (1) SUBMISSION OF APPLICATION.—

18 (A) FORM; CONTENT.—To apply for a cer-  
19 tificate of review, a person shall submit to the  
20 Attorney General a written application which—

21 (i) specifies the activities relating to  
22 the provision of health care services which  
23 satisfy the criteria described in section  
24 522(f) and which will be included in the  
25 certificate; and

1 (ii) is in a form and contains any in-  
2 formation, including information pertain-  
3 ing to the overall market in which the ap-  
4 plicant operates, required by rule or regu-  
5 lation promulgated under section 526.

6 (B) FILING FEE.—The Attorney General  
7 may require a filing fee to be submitted with  
8 the application to cover the cost of publication  
9 and the cost of review required by this section.  
10 The amount of the filing fee shall be deter-  
11 mined on a sliding scale established by the At-  
12 torney General in consultation with the Chair  
13 (based on the monetary size of the transaction  
14 involved), except that such fee may not exceed  
15 \$5,000.

16 (2) PUBLICATION OF NOTICE IN FEDERAL REG-  
17 ISTER.—Within 10 days after an application submit-  
18 ted under paragraph (1) is received by the Attorney  
19 General, the Attorney General shall publish in the  
20 Federal Register a notice that announces that an  
21 application for a certificate of review has been sub-  
22 mitted, identifies each person submitting the appli-  
23 cation, and describes the conduct for which the ap-  
24 plication is submitted.



1           (3) ESTABLISHMENT OF PROCEDURES FOR IS-  
2       SUANCE OF CERTIFICATE.—In consultation with the  
3       Chair and the Secretary, the Attorney General shall  
4       establish procedures to be used in applying for and  
5       in determining whether to approve an application for  
6       a certificate of review under this subtitle. Under  
7       such procedures the Attorney General, in consulta-  
8       tion with the Secretary, shall approve an application  
9       if the Attorney General determines that the activities  
10      to be covered under the certificate will satisfy the  
11      criteria described in section 522(f) for safe harbors  
12      designated under such section and that the benefits  
13      of the issuance of the certificate will outweigh any  
14      disadvantages that may result from reduced com-  
15      petition. If the Attorney General, with the concur-  
16      rence of the Secretary, determines that the require-  
17      ments for a certificate are met, the Attorney General  
18      shall issue to the applicant a certificate of review.  
19      The certificate of review shall specify—  
20                (i) the health care market activities to  
21                which the certificate applies,  
22                (ii) the person to whom the certificate  
23                of review is issued, and  
24                (iii) any terms and conditions the At-  
25                torney General or the Secretary deems nec-

1           essary to assure compliance with the appli-  
2           cable procedures described in paragraph  
3           (3).

4           (4) TIMING FOR DECISION ON APPLICATION.—  
5       Within 90 days after the Attorney General receives  
6       an application for a certificate of review, the Attor-  
7       ney General shall determine whether to grant or  
8       deny the certificate.

9           (5) NOTIFICATION OF DECISION.—The Attor-  
10      ney General shall notify the applicant of the Attor-  
11      ney General's determination and, if the application  
12      is denied, the reasons for the denial.

13          (6) FRAUDULENT PROCUREMENT.—A certifi-  
14      cate of review shall be void ab initio with respect to  
15      any health care market activities for which the cer-  
16      tificate was procured by fraud.

17      (c) AMENDMENT AND REVOCATION OF CERTIFI-  
18      CATES.—

19          (1) NOTIFICATION OF CHANGES.—Any appli-  
20      cant who receives a certificate of review—

21              (A) shall promptly report to the Attorney  
22              General any change relevant to the matters  
23              specified in the certificate; and

24              (B) may submit to the Attorney General  
25      an application to amend the certificate to re-

1           flect the effect of the change on the conduct  
2           specified in the certificate.

3           (2) AMENDMENT TO CERTIFICATE.—An appli-  
4           cation for an amendment to a certificate of review  
5           shall be treated as an application for the issuance of  
6           a certificate. The effective date of an amendment  
7           shall be the date on which the application for the  
8           amendment is received by the Attorney General.

9           (3) REVOCATION.—

10           (A) GROUNDS FOR REVOCATION.—In ac-  
11           cordance with this paragraph, the Attorney  
12           General, in consultation with the Secretary,  
13           may revoke in whole or in part a certificate of  
14           review issued under this section based on one or  
15           more of the following grounds:

16           (i) After the expiration of the 2-year  
17           period beginning on the date a person's  
18           certificate is issued, the activities of the  
19           person have not substantially accomplished  
20           the purposes for the issuance of the certifi-  
21           cate.

22           (ii) The person has failed to comply  
23           with any of the terms or conditions im-  
24           posed under the certificate by the Attorney

1           General or the Secretary under subsection  
2           (b)(4).

3           (iii) The activities covered under the  
4           certificate no longer satisfy the criteria set  
5           forth in section 522(f).

6           (B) REQUEST FOR COMPLIANCE INFORMA-  
7           TION.—If the Attorney General or the Sec-  
8           retary has reason to believe that any of the  
9           grounds for revocation of a certificate of review  
10          described in subparagraph (A) may apply to a  
11          person holding the certificate, the Attorney  
12          General shall request such information from  
13          such person as the Attorney General or the Sec-  
14          retary deems necessary to resolve the matter of  
15          compliance. Failure to comply with such request  
16          shall be grounds for revocation of the certificate  
17          under this paragraph.

18          (C) PROCEDURES FOR REVOCATION.—If  
19          the Attorney General or the Secretary deter-  
20          mines that any of the grounds for revocation of  
21          a certificate of review described in subpara-  
22          graph (A) apply to a person holding the certifi-  
23          cate, or that such person has failed to comply  
24          with a request made under subparagraph (B),  
25          the Attorney General shall give written notice of

1           the determination to such person. The notice  
2           shall include a statement of the circumstances  
3           underlying, and the reasons in support of, the  
4           determination. In the 60-day period beginning  
5           30 days after the notice is given, the Attorney  
6           General shall revoke the certificate or modify it  
7           as the Attorney General or the Secretary deems  
8           necessary to cause the certificate to apply only  
9           to activities that meet the criteria set forth in  
10          section 522(f).

11           (D) INVESTIGATION AUTHORITY.—For  
12          purposes of carrying out this paragraph, the  
13          Attorney General may conduct investigations in  
14          the same manner as the Attorney General con-  
15          ducts investigations under section 3 of the Anti-  
16          trust Civil Process Act, except that no civil in-  
17          vestigative demand may be issued to a person  
18          to whom a certificate of review is issued if such  
19          person is the target of such investigation.

20          (d) REVIEW OF DETERMINATIONS.—

21           (1) AVAILABILITY OF REVIEW FOR CERTAIN AC-  
22          TIONS.—If the Attorney General denies, in whole or  
23          in part, an application for a certificate of review or  
24          for an amendment to a certificate, or revokes or  
25          modifies a certificate pursuant to paragraph (3), the

1 applicant or certificate holder (as the case may be)  
2 may, within 30 days of the denial or revocation,  
3 bring an action in the United States District Court  
4 for the District of Columbia to set aside the deter-  
5 mination on the ground that such determination is  
6 clearly erroneous.

7 (2) NO OTHER REVIEW PERMITTED.—Except  
8 as provided in paragraph (1), no action by the At-  
9 torney General, the Chair, or the Secretary pursuant  
10 to this subtitle shall be subject to judicial review.

11 (3) EFFECT OF REJECTED APPLICATION.—If  
12 the Attorney General denies, in whole or in part, an  
13 application for a certificate of review or for an  
14 amendment to a certificate, or revokes or amends a  
15 certificate, neither the negative determination nor  
16 the statement of reasons therefore shall be admissi-  
17 ble in evidence, in any administrative or judicial pro-  
18 ceeding, concerning any claim under the antitrust  
19 laws.

20 (e) PUBLICATION OF DECISIONS.—The Attorney  
21 General shall publish a notice in the Federal Register on  
22 a timely basis of each decision made with respect to an  
23 application for a certificate of review under this section  
24 or the amendment or revocation of such a certificate, in

1 a manner that protects the confidentiality of any propri-  
2 etary information relating to the application.

3 (f) ANNUAL REPORTS.—Every person to whom a cer-  
4 tificate of review is issued shall submit to the Attorney  
5 General an annual report, in such form and at such time  
6 as the Attorney General may require, that contains any  
7 necessary updates to the information required under sub-  
8 section (b) and a description of the activities of the holder  
9 under the certificate during the preceding year.

10 (g) RESTRICTIONS ON DISCLOSURE OF INFORMA-  
11 TION.—

12 (1) WAIVER OF DISCLOSURE REQUIREMENTS  
13 UNDER ADMINISTRATIVE PROCEDURE ACT.—Infor-  
14 mation submitted by any person in connection with  
15 the issuance, amendment, or revocation of a certifi-  
16 cate of review shall be exempt from disclosure under  
17 section 552 of title 5, United States Code.

18 (2) RESTRICTIONS ON DISCLOSURE OF COM-  
19 MERCIAL OR FINANCIAL INFORMATION.—

20 (A) IN GENERAL.—Except as provided in  
21 subparagraph (B), no officer or employee of the  
22 United States shall disclose commercial or fi-  
23 nancial information submitted in connection  
24 with the issuance, amendment, or revocation of  
25 a certificate of review if the information is priv-

1           ileged or confidential or if disclosure of the in-  
2           formation would cause harm to the person who  
3           submitted the information.

4           (B)   EXCEPTIONS.—Subparagraph   (A)  
5           shall not apply with respect to information dis-  
6           closed—

7                   (i) upon a request made by the Con-  
8                   gress or any committee of the Congress,

9                   (ii) in a judicial or administrative pro-  
10                  ceeding, subject to appropriate protective  
11                  orders,

12                  (iii) with the consent of the person  
13                  who submitted the information,

14                  (iv) in the course of making a deter-  
15                  mination with respect to the issuance,  
16                  amendment, or revocation of a certificate  
17                  of review, if the Attorney General deems  
18                  disclosure of the information to be nec-  
19                  essary in connection with making the de-  
20                  termination,

21                  (v) in accordance with any require-  
22                  ment imposed by a statute of the United  
23                  States, or

24                  (vi) in accordance with any rule or  
25                  regulation promulgated under subsection



1 (i) permitting the disclosure of the infor-  
2 mation to an agency of the United States  
3 or of a State on the condition that the  
4 agency will disclose the information only  
5 under the circumstances specified in  
6 clauses (i) through (v).

7 (3) PROHIBITION AGAINST USE OF INFORMA-  
8 TION TO SUPPORT OR ANSWER CLAIMS UNDER ANTI-  
9 TRUST LAWS.—Any information disclosed in an ap-  
10 plication for a certificate of review under this section  
11 shall only be admissible into evidence in a judicial or  
12 administrative proceeding for the sole purpose of es-  
13 tablishing whether a person is entitled to the protec-  
14 tions provided by such a certificate.

15 **SEC. 524. NOTIFICATIONS PROVIDING REDUCTION IN CER-**  
16 **TAIN PENALTIES UNDER ANTITRUST LAW**  
17 **FOR HEALTH CARE JOINT VENTURES.**

18 (a) NOTIFICATIONS DESCRIBED.—

19 (1) SUBMISSION OF NOTIFICATION BY VEN-  
20 TURE.—Any party to a health care joint venture,  
21 acting on such venture's behalf, may, not later than  
22 90 days after entering into a written agreement to  
23 form such venture or not later than 90 days after  
24 the date of the enactment of this Act, whichever is

1 later, file with the Attorney General a written notifi-  
2 cation disclosing—

3 (A) the identities of the parties to such  
4 venture,

5 (B) the nature and objectives of such ven-  
6 ture, and

7 (C) such additional information as the At-  
8 torney General may require by regulation.

9 (2) FILING FEE.—The Attorney General may  
10 require a filing fee to be submitted with the notifica-  
11 tion to cover the cost of publication and the cost of  
12 administering this section, except that the amount of  
13 such fee shall not exceed \$250.

14 (3) SUBMISSION OF ADDITIONAL INFORMA-  
15 TION.—

16 (A) REQUEST OF ATTORNEY GENERAL.—  
17 At any time after receiving a notification filed  
18 under paragraph (1), the Attorney General may  
19 require the submission of additional information  
20 or documentary material relevant to the pro-  
21 posed health care joint venture.

22 (B) PARTIES TO VENTURE.—Any party to  
23 a health care joint venture may submit such ad-  
24 ditional information on the venture's behalf as  
25 may be appropriate to ensure that the venture

1 will receive the protections provided under sub-  
2 section (b).

3 (C) REQUIRED SUBMISSION OF INFORMA-  
4 TION ON CHANGES TO VENTURE.—A health  
5 care joint venture for which a notification is in  
6 effect under this section shall submit informa-  
7 tion on any change in the membership of the  
8 venture not later than 90 days after such  
9 change occurs.

10 (4) PUBLICATION OF NOTIFICATION.—

11 (A) INFORMATION MADE PUBLICLY AVAIL-  
12 ABLE.—Not later than 30 days after receiving  
13 a notification with respect to a venture under  
14 paragraph (1), the Attorney General shall pub-  
15 lish in the Federal Register a notice with re-  
16 spect to the venture that identifies the parties  
17 to the venture and generally describes the pur-  
18 pose and planned activity of the venture. Prior  
19 to its publication, the contents of the notice  
20 shall be made available to the parties to the  
21 venture.

22 (B) RESTRICTION ON DISCLOSURE OF  
23 OTHER INFORMATION.—All information and  
24 documentary material submitted pursuant to  
25 this section and all information obtained by the

1 Attorney General in the course of any investiga-  
2 tion or case with respect to a potential violation  
3 of the antitrust laws by the health care joint  
4 venture (other than information and material  
5 described in subparagraph (A)) shall be exempt  
6 from disclosure under section 552 of title 5,  
7 United States Code, and shall not be made pub-  
8 licly available by any agency of the United  
9 States to which such section applies except in  
10 a judicial proceeding in which such information  
11 and material is subject to any protective order.

12 (5) WITHDRAWAL OF NOTIFICATION.—Any per-  
13 son who files a notification pursuant to this section  
14 may withdraw such notification before a publication  
15 by the Attorney General pursuant to paragraph (4).

16 (6) NO JUDICIAL REVIEW PERMITTED.—Any  
17 action taken or not taken by the Attorney General  
18 with respect to notifications filed pursuant to this  
19 subsection shall not be subject to judicial review.

20 (b) PROTECTIONS FOR VENTURES SUBJECT TO NO-  
21 TIFICATION.—

22 (1) IN GENERAL.—

23 (A) PROTECTIONS DESCRIBED.—Except as  
24 provided in subsection (c), the provisions of  
25 paragraphs (2), (3), (4), and (5) shall apply

1 with respect to any action under the antitrust  
2 laws challenging conduct within the scope of a  
3 notification which is in effect pursuant to sub-  
4 section (a)(1).

5 (B) TIMING OF PROTECTIONS.—The pro-  
6 tections described in this subsection shall apply  
7 to the venture that is the subject of a notifica-  
8 tion under subsection (a)(1) as of the earlier  
9 of—

10 (i) the date of the publication in the  
11 Federal Register of the notice published  
12 with respect to the notification; or

13 (ii) if such notice is not published dur-  
14 ing the period required under subsection  
15 (a)(4), the expiration of the 30-day period  
16 that begins on the date the Attorney Gen-  
17 eral receives any necessary information re-  
18 quired to be submitted under subsection  
19 (a)(1) or any additional information re-  
20 quired by the Attorney General under sub-  
21 section (a)(3)(A).

22 (2) APPLICABILITY OF RULE OF REASON  
23 STANDARD.—In any action under the antitrust laws,  
24 the conduct of any person which is within the scope  
25 of a notification filed under subsection (a) shall not

1 be deemed illegal per se, but shall be judged on the  
2 basis of its reasonableness, taking into account all  
3 relevant factors affecting competition, including, but  
4 not limited to, effects on competition in relevant  
5 markets.

6 (3) LIMITATION ON RECOVERY TO ACTUAL  
7 DAMAGES AND INTEREST.—Notwithstanding section  
8 4 of the Clayton Act, any person who is entitled to  
9 recovery under the antitrust laws for conduct that is  
10 within the scope of a notification filed under sub-  
11 section (a) shall recover the actual damages sus-  
12 tained by such person and interest calculated at the  
13 rate specified in section 1961 of title 28, United  
14 States Code, for the period beginning on the earliest  
15 date for which injury can be established and ending  
16 on the date of judgment, unless the court finds that  
17 the award of all or part of such interest is unjust  
18 under the circumstances.

19 (4) AWARD OF ATTORNEY'S FEES AND COSTS  
20 OF SUIT.—

21 (A) IN GENERAL.—In any action under the  
22 antitrust laws brought against a health care  
23 joint venture for conduct that is within the  
24 scope of a notification filed under subsection

1 (a), the court shall, at the conclusion of the ac-  
2 tion—

3 (i) award to a substantially prevailing  
4 claimant the cost of suit attributable to  
5 such claim, including a reasonable attor-  
6 ney's fee, or

7 (ii) award to a substantially prevailing  
8 party defending against such claim the  
9 cost of such suit attributable to such claim,  
10 including reasonable attorney's fee, if the  
11 claim, or the claimant's conduct during  
12 litigation of the claim, was frivolous, un-  
13 reasonable, without foundation, or in bad  
14 faith.

15 (B) OFFSET IN CASES OF BAD FAITH.—

16 The court may reduce an award made pursuant  
17 to subparagraph (A) in whole or in part by an  
18 award in favor of another party for any part of  
19 the cost of suit (including a reasonable attor-  
20 ney's fee) attributable to conduct during the  
21 litigation by any prevailing party that the court  
22 finds to be frivolous, unreasonable, without  
23 foundation, or in bad faith.

24 (5) RESTRICTIONS ON ADMISSIBILITY OF IN-  
25 FORMATION.—

1 (A) IN GENERAL.—Any information dis-  
 2 closed in a notification submitted under sub-  
 3 section (a)(1) and the fact of the publication of  
 4 a notification by the Attorney General under  
 5 subsection (a)(4) shall only be admissible into  
 6 evidence in a judicial or administrative proceed-  
 7 ing for the sole purpose of establishing whether  
 8 a party to a health care joint venture is entitled  
 9 to the protections described in this subsection.

10 (B) ACTIONS OF ATTORNEY GENERAL.—  
 11 No action taken by the Attorney General pursu-  
 12 ant to this section shall be admissible into evi-  
 13 dence in any judicial or administrative proceed-  
 14 ing for the purpose of supporting or answering  
 15 any claim under the antitrust laws.

16 (c) EXCEPTION FOR CERTAIN ACTIVITIES.—In the  
 17 event the parties cannot show procompetitive aspects nec-  
 18 essary to the success of the joint venture, the protections  
 19 described in subsection (b) should not be construed to  
 20 apply to conduct which constitutes per se price-fixing, bid-  
 21 rigging, or market allocation.

22 **SEC. 525. REVIEW AND REPORTS ON SAFE HARBORS, CER-**  
 23 **TIFICATES OF REVIEW, AND NOTIFICATIONS.**

24 (a) IN GENERAL.—The Attorney General, in con-  
 25 sultation with the Secretary and the Chair, shall periodi-



1 cally review the safe harbors designated under section 522,  
2 the certificates of review issued under section 523, and  
3 notification received under section 524, and—

4 (1) with respect to the safe harbors, issue modi-  
5 fications to such safe harbors in such manner as the  
6 Attorney General considers appropriate in accord-  
7 ance with the requirements of section 522(f), which  
8 modifications shall take effect 90 days after issu-  
9 ance, unless disapproved by the Congress; and

10 (2) with respect to the certificates of review and  
11 notifications, submit a report to Congress on the is-  
12 suance of such certificates and receipt of notifica-  
13 tions, including a description of the effect of such  
14 certificates and notifications on increasing access to  
15 high quality health care services at reduced costs.

16 (b) RECOMMENDATIONS FOR LEGISLATION.—The  
17 Attorney General shall include in the reports submitted  
18 under subsection (a)(2) any recommendations of the At-  
19 torney General for legislation to improve the programs for  
20 the issuance of certificates of review and receipt of notifi-  
21 cations established under this subtitle.

22 **SEC. 526. RULES, REGULATIONS, AND GUIDELINES.**

23 (a) SAFE HARBORS, CERTIFICATES, AND NOTIFICA-  
24 TIONS.—The Attorney General, in consultation with the  
25 Secretary and the Chair, shall promulgate such rules, reg-

1   ulations, and guidelines as are necessary to carry out sec-  
2   tions 522, 523, and 524.

3       (b) GUIDANCE FOR PROVIDERS.—

4           (1) IN GENERAL.—To promote greater cer-  
5   tainty regarding the application of the antitrust laws  
6   to activities in the health care market, the Attorney  
7   General, in consultation with the Secretary and the  
8   Chair, shall (not later than 1 year after the date of  
9   the enactment of this Act), taking into account the  
10  criteria used to designate safe harbors under section  
11  522 and to grant certificates of review under section  
12  523, publish guidelines—

13           (A) to define or provide assistance in de-  
14   termining relevant geographic and product mar-  
15   kets for health care services and providers of  
16   health care services;

17           (B) to further collaborative activities which  
18   may be helpful to enhance services in under-  
19   served and geographically disadvantaged areas  
20   such as rural markets and inner cities;

21           (C) to assist collaboration between provid-  
22   ers (such as hospital networks, physician-hos-  
23   pital organizations, and other groups of provid-  
24   ers) which will help provide health care services  
25   more efficiently;

1 (D) to further activities by which public  
2 health clinics (including community health cen-  
3 ters and migrant health centers under title III  
4 of the Public Health Service Act) may partici-  
5 pate in networks and other collaborative activi-  
6 ties in order to enhance services in underserved  
7 areas;

8 (E) to assist providers of health care serv-  
9 ices in analyzing whether the activities of such  
10 providers may be subject to a safe harbor under  
11 section 522;

12 (F) to provide clarification for activities in  
13 the general subject matter areas described in  
14 the safe harbors in section 522, but which fall  
15 outside the safe harbors; and

16 (G) to describe specific types of activities  
17 which would meet the requirements for issuance  
18 of a certificate of review under section 523, and  
19 summarizing the factual and legal bases on  
20 which the activities would meet the require-  
21 ments.

22 (2) PERIODIC UPDATE.—The Attorney General  
23 shall periodically update the guidelines published  
24 under paragraph (1) as the Attorney General consid-  
25 ers appropriate.

1           (3) WAIVER OF ADMINISTRATIVE PROCEDURE  
2       ACT.—Section 553 of title 5, United States Code,  
3       shall not apply to the issuance of guidelines under  
4       paragraph (1).

5   **SEC. 527. DEFINITIONS.**

6       In this subtitle, the following definitions shall apply:

7           (1) The term “antitrust laws”—

8               (A) has the meaning given it in subsection  
9               (a) of the first section of the Clayton Act (15  
10              U.S.C. 12(a)), except that such term includes  
11              section 5 of the Federal Trade Commission Act  
12              (15 U.S.C. 45) to the extent such section ap-  
13              plies to unfair methods of competition; and

14               (B) includes any State law similar to the  
15              laws referred to in subparagraph (A).

16           (2) The term “Chair” means the Chair of the  
17       Federal Trade Commission.

18           (3) The term “health benefit plan” means any  
19       hospital or medical expense incurred policy or certifi-  
20       cate, hospital or medical service plan contract, or  
21       health maintenance subscriber contract, or a mul-  
22       tiple employer welfare arrangement or employee ben-  
23       efit plan (as defined under the Employee Retirement  
24       Income Security Act of 1974) which provides bene-  
25       fits with respect to health care services.

1           (4) The term “health care joint venture” means  
2           a joint venture of 2 or more persons formed for the  
3           purpose of providing health care services, including  
4           attempts to enter into or perform a contract or  
5           agreement to provide such services.

6           (5) The term “health care services” means any  
7           services for which payment may be made under a  
8           health benefit plan, including services related to the  
9           delivery or administration of such services.

10          (6) The term “medical self-regulatory entity”  
11          means a medical society or association, a specialty  
12          board, a recognized accrediting agency, or a hospital  
13          medical staff, and includes the members, officers,  
14          employees, consultants, and volunteers or commit-  
15          tees of such an entity.

16          (7) The term “person” includes a State or unit  
17          of local government.

18          (8) The term “provider of health care services”  
19          means any individual or entity that is engaged in the  
20          delivery of health care services in a State and that  
21          is required by State law or regulation to be licensed  
22          or certified by the State to engage in the delivery of  
23          such services in the State.

24          (9) The term “Secretary” means the Secretary  
25          of Health and Human Services.

1           (10) The term “specialty group” means a medi-  
2       cal specialty or subspecialty in which a provider of  
3       health care services may be licensed to practice by  
4       a State (as determined by the Secretary in consulta-  
5       tion with the certification boards for such specialties  
6       and subspecialties).

7           (11) The term “standard setting and enforce-  
8       ment activities” means—

9                   (A) accreditation of health care practition-  
10       ers, health care providers, medical education in-  
11       stitutions, or medical education programs,

12                   (B) technology assessment and risk man-  
13       agement activities,

14                   (C) the development and implementation of  
15       practice guidelines or practice parameters, or

16                   (D) official peer review proceedings under-  
17       taken by a hospital medical staff (or committee  
18       thereof) or a medical society or association for  
19       purposes of evaluating the professional conduct  
20       or quality of health care provided by a medical  
21       professional.

## 22       **TITLE VI—ADMINISTRATIVE** 23       **SIMPLIFICATION AND PRIVACY**

### 24       **SEC. 601. ADMINISTRATIVE SIMPLIFICATION.**

25       (a) HEALTH INFORMATION NETWORK.—

1 (1) IN GENERAL.—Title XI of the Social Secu-  
 2 rity Act (42 U.S.C. 1301 et seq.) is amended by  
 3 adding at the end the following new subtitle:

4 **“Subtitle B—Administrative**  
 5 **Simplification**

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“Sec. 11741. Standards and certification for health information network  
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- “Sec. 11771. General requirement on Secretary.
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“PART IX—DEMONSTRATION PROJECTS FOR COMMUNITY-BASED CLINICAL  
INFORMATION SYSTEMS

- “Sec. 11781. Grants for demonstration projects.

1           **“PART I—PURPOSE AND DEFINITIONS**

2   **“SEC. 11701. PURPOSE.**

3           “‘It is the purpose of this subtitle to improve the effi-  
4   ciency and effectiveness of the health care system, includ-  
5   ing the medicare program under title XVIII and the med-  
6   icaid program under title XIX, by encouraging the devel-  
7   opment of a health information network through the es-  
8   tablishment of standards and requirements for the elec-  
9   tronic transmission of certain health information.

10 **“SEC. 11702. DEFINITIONS.**

11           “‘For purposes of this subtitle:

12           “(1) CODE SET.—The term ‘code set’ means  
13   any set of codes used for encoding data elements,  
14   such as tables of terms, medical concepts, medical  
15   diagnostic codes, or medical procedure codes.

16           “(2) COORDINATION OF BENEFITS.—The term  
17   ‘coordination of benefits’ means determining and co-  
18   ordinating the financial obligations of health plans



1 when health care benefits are payable under 2 or  
2 more health plans.

3 “(3) HEALTH CARE PROVIDER.—The term  
4 ‘health care provider’ includes a provider of services  
5 (as defined in section 1861(u)), a provider of medi-  
6 cal or other health services (as defined in section  
7 1861(s)), and any other person furnishing health  
8 care services or supplies.

9 “(4) HEALTH INFORMATION.—The term ‘health  
10 information’ means any information, whether oral or  
11 recorded in any form or medium that—

12 “(A) is created or received by a health care  
13 provider, health plan, health oversight agency  
14 (as defined in section 11802), health re-  
15 searcher, public health authority (as defined in  
16 section 11802), employer, life insurer, school or  
17 university, or health information network serv-  
18 ice certified under section 11741; and

19 “(B) relates to the past, present, or future  
20 physical or mental health or condition of an in-  
21 dividual, the provision of health care to an indi-  
22 vidual, or the past, present, or future payment  
23 for the provision of health care to an individual.

24 “(5) HEALTH INFORMATION NETWORK.—The  
25 term ‘health information network’ means the health

1 information system that is formed through the appli-  
2 cation of the requirements and standards established  
3 under this subtitle.

4 “(6) HEALTH INFORMATION PROTECTION OR-  
5 GANIZATION.—The term ‘health information protec-  
6 tion organization’ means a private entity or an en-  
7 tity operated by a State that accesses standard data  
8 elements of health information through the health  
9 information network, processes such information  
10 into non-identifiable health information, and may  
11 store such information.

12 “(7) HEALTH INFORMATION NETWORK SERV-  
13 ICE.—The term ‘health information network serv-  
14 ice’—

15 “(A) means a private entity or an entity  
16 operated by a State that enters into contracts  
17 to—

18 “(i) process or facilitate the process-  
19 ing of nonstandard data elements of health  
20 information into standard data elements;

21 “(ii) provide the means by which per-  
22 sons are connected to the health informa-  
23 tion network for purposes of meeting the  
24 requirements of this subtitle, including the

1 holding of standard data elements of  
2 health information;

3 “(iii) provide authorized access to  
4 health information through the health in-  
5 formation network; or

6 “(iv) provide specific information  
7 processing services, such as automated co-  
8 ordination of benefits and claims trans-  
9 action routing; and

10 “(B) includes a health information protec-  
11 tion organization.

12 “(8) HEALTH PLAN.—The term ‘health plan’  
13 has the meaning given such term in section  
14 21003(a)(1) except that such term shall include sub-  
15 paragraphs (C), (D), (E), (F), and (H) of such sec-  
16 tion.

17 “(9) NON-IDENTIFIABLE HEALTH INFORMA-  
18 TION.—The term ‘non-identifiable health informa-  
19 tion’ means health information that is not protected  
20 health information as defined in section 11802.

21 “(10) HEALTH RESEARCHER.—The term  
22 ‘health researcher’ shall have the meaning given  
23 such term under section 11802.

24 “(11) PATIENT MEDICAL RECORD INFORMA-  
25 TION.—The term ‘patient medical record informa-

1       tion’ means health information derived from a clinical  
 2       cal encounter that relates to the physical or mental  
 3       condition of an individual.

4           “(12) STANDARD.—The term ‘standard’ when  
 5       referring to an information transaction or to data  
 6       elements of health information means the trans-  
 7       action or data elements meet any standard adopted  
 8       by the Secretary under part II that applies to such  
 9       information transaction or data elements.

10       **“PART II—STANDARDS FOR DATA ELEMENTS**  
 11           **AND INFORMATION TRANSACTIONS**

12       **“SEC. 11711. GENERAL REQUIREMENTS ON SECRETARY.**

13           “(a) IN GENERAL.—The Secretary shall adopt stand-  
 14       ards and modifications to standards under this subtitle  
 15       that are—

16           “(1) consistent with the objective of reducing  
 17       the costs of providing and paying for health care;  
 18       and

19           “(2) in use and generally accepted or developed  
 20       or modified by the standards setting organizations  
 21       accredited by the American National Standard Insti-  
 22       tute (ANSI).

23           “(b) INITIAL STANDARDS.—The Secretary may de-  
 24       velop an expedited process for the adoption of initial  
 25       standards under this subtitle.

1       “(c) PAPER FORMATS.—The Secretary may develop  
 2 methods by which a person may use the standards adopted  
 3 by the Secretary under this subtitle with respect to health  
 4 information that is in written rather than electronic form.

5       **“SEC. 11712. STANDARDS FOR DATA ELEMENTS OF HEALTH**  
 6                               **INFORMATION.**

7       “(a) IN GENERAL.—The Secretary shall adopt stand-  
 8 ards necessary to make data elements of the following  
 9 health information uniform and compatible for electronic  
 10 transmission through the health information network:

11               “(1) the health information that is appropriate  
 12 for transmission in connection with transactions de-  
 13 scribed in subsections (a) and (b) of section 11721;

14               “(2) any quality information required to be sub-  
 15 mitted by a health plan to a State under title XXI;  
 16 and

17               “(3) patient medical record information.

18       “(b) ADDITIONS.—The Secretary may make addi-  
 19 tions to the sets of data elements adopted under sub-  
 20 section (a) as the Secretary determines appropriate in a  
 21 manner that minimizes the disruption and cost of compli-  
 22 ance with such additions.

23       “(c) CERTAIN DATA ELEMENTS.—

24               “(1) UNIQUE HEALTH IDENTIFIERS.—The Sec-  
 25 retary shall adopt standards for a standard unique

1 health identifier for each individual, employer, health  
2 plan, and health care provider for use in the health  
3 care system.

4 “(2) CODE SETS.—

5 “(A) IN GENERAL.—The Secretary, in con-  
6 sultation with experts from the private sector  
7 and Federal agencies, shall—

8 “(i) select code sets for appropriate  
9 data elements from among the code sets  
10 that have been developed by private and  
11 public entities; or

12 “(ii) establish code sets for such data  
13 elements if no code sets for the data ele-  
14 ments have been developed.

15 “(B) DISTRIBUTION.—The Secretary shall  
16 establish efficient and low-cost procedures for  
17 distribution of code sets and modifications to  
18 such code sets under section 11714(c).

19 **“SEC. 11713. INFORMATION TRANSACTION STANDARDS.**

20 “(a) IN GENERAL.—The Secretary shall adopt tech-  
21 nical standards relating to the method by which data ele-  
22 ments of health information that have been standardized  
23 under section 11712 may be transmitted electronically, in-  
24 cluding standards with respect to the format in which such  
25 data elements shall be transmitted.

1       “(b) SPECIAL RULE FOR COORDINATION OF BENE-  
 2 FITS.—Any standards adopted by the Secretary under  
 3 paragraph (1) that relate to coordination of benefits shall  
 4 provide that a claim for reimbursement for medical serv-  
 5 ices furnished is tested by an algorithm specified by the  
 6 Secretary against all records of enrollment and eligibility  
 7 for the individual who received such services to determine  
 8 any primary and secondary obligors for payment.

9       “(c) ELECTRONIC SIGNATURE.—The Secretary, in  
 10 coordination with the Secretary of Commerce, shall pro-  
 11 mulgate regulations specifying procedures for the elec-  
 12 tronic transmission and authentication of signatures, com-  
 13 pliance with which will be deemed to satisfy State and  
 14 Federal statutory requirements for written signatures with  
 15 respect to information transactions required by this Act  
 16 and written signatures on medical records and prescrip-  
 17 tions.

18 **“SEC. 11714. TIMETABLES FOR ADOPTION OF STANDARDS.**

19       “(a) INITIAL STANDARDS FOR DATA ELEMENTS.—  
 20 The Secretary shall adopt standards relating to—

21               “(1) the data elements for the information de-  
 22 scribed in section 11712(a)(1) not later than 9  
 23 months after the date of the enactment of this sub-  
 24 title (except in the case of standards with respect to  
 25 data elements for claims attachments which shall be

1       adopted not later than 24 months after the date of  
2       the enactment of this subtitle);

3           “(2) the data elements for the information de-  
4       scribed in section 11712(a)(2) not later than 9  
5       months after the date of the enactment of this sub-  
6       title;

7           “(3) data elements for patient medical record  
8       information not earlier than 5 years and not later  
9       than 10 years after the date of the enactment of this  
10      subtitle; and

11          “(4) any addition to a set of data elements, in  
12      conjunction with making such an addition.

13          “(b) INITIAL STANDARDS FOR INFORMATION TRANS-  
14      ACTIONS.—The Secretary shall adopt standards relating  
15      to information transactions under section 11713 not later  
16      than 9 months after the date of the enactment of this sub-  
17      title (except in the case of standards for claims attach-  
18      ments which shall be adopted not later than 24 months  
19      after the date of the enactment of this subtitle).

20          “(c) MODIFICATIONS TO STANDARDS.—

21           “(1) IN GENERAL.—Except as provided in para-  
22      graph (2), the Secretary shall review the standards  
23      adopted under this subtitle and shall adopt modified  
24      standards as determined appropriate, but no more  
25      frequently than once every 6 months. Any modifica-



1       tion to standards shall be completed in a manner  
2       which minimizes the disruption and cost of compli-  
3       ance.

4           “(2) SPECIAL RULES.—

5               “(A) MODIFICATIONS DURING FIRST 12-  
6       MONTH PERIOD.—Except with respect to addi-  
7       tions and modifications to code sets under sub-  
8       paragraph (B), the Secretary shall not adopt  
9       any modifications to standards adopted under  
10      this subtitle during the 12-month period begin-  
11      ning on the date such standards are adopted  
12      unless the Secretary determines that a modi-  
13      fication is necessary in order to permit compli-  
14      ance with requirements relating to the stand-  
15      ards.

16           “(B) ADDITIONS AND MODIFICATIONS TO  
17      CODE SETS.—

18               “(i) IN GENERAL.—The Secretary  
19       shall ensure that procedures exist for the  
20       routine maintenance, testing, enhancement,  
21       and expansion of code sets to accommodate  
22       changes in biomedical science and health  
23       care delivery.

24               “(ii) ADDITIONAL RULES.—If a code  
25       set is modified under this subsection, the

1           modified code set shall include instructions  
2           on how data elements that were encoded  
3           prior to the modification are to be con-  
4           verted or translated so as to preserve the  
5           value of the data elements. Any modifica-  
6           tion to a code set under this subsection  
7           shall be implemented in a manner that  
8           minimizes the disruption and cost of com-  
9           plying with such modification.

10       “(d) EVALUATION OF STANDARDS.—The Secretary  
11 may establish a process to measure or verify the consist-  
12 ency of standards adopted or modified under this subtitle.  
13 Such process may include demonstration projects and  
14 analysis of the cost of implementing such standards and  
15 modifications.

16       **“PART III—REQUIREMENTS WITH RESPECT TO**  
17       **CERTAIN TRANSACTIONS AND INFORMATION**

18       **“SEC. 11721. REQUIREMENTS WITH RESPECT TO CERTAIN**  
19       **TRANSACTIONS AND INFORMATION.**

20       “(a) REQUIREMENTS ON PLANS AND PROVIDERS RE-  
21 LATING TO FINANCIAL AND ADMINISTRATIVE TRANS-  
22 ACTIONS.—If a health care provider or a health plan con-  
23 ducts any of the following transactions, such transactions  
24 shall be standard transactions and the information trans-

mitted or received in connection with such transaction  
shall be in the form of standard data elements:

“(1) Claims (including coordination of benefits).

“(2) Claims attachments.

“(3) Responses to research inquiries by a health  
researcher.

“(3) Other transactions determined appropriate  
by the Secretary consistent with the goal of reducing  
administrative costs.

“(b) REQUIREMENT ONLY ON PLANS RELATING TO  
FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—If a  
person desires to conduct any of the following transactions  
with a health plan as a standard transaction, the health  
plan shall conduct such standard transaction and the in-  
formation transmitted or received in connection with such  
transaction shall be in the form of standard data elements:

“(1) Enrollment and disenrollment.

“(2) Eligibility.

“(3) Payment and remittance advice.

“(4) Premium payments.

“(5) First report of injury.

“(6) Claims status.

“(7) Referral certification and authorization.

1           “(8) Other transactions determined appropriate  
2           by the Secretary consistent with the goal of reducing  
3           administrative costs.

4           “(c) REQUIREMENT ON PLANS RELATING TO QUAL-  
5   ITY INFORMATION.—Any quality information required to  
6   be submitted by a health plan to a State under title XXI  
7   shall be in the form of standard data elements and the  
8   transmission of such data shall be in the form of a stand-  
9   ard transaction.

10          “(d) REQUIREMENT WITH RESPECT TO DISCLOSURE  
11   OF INFORMATION.—

12           “(1) IN GENERAL.—A health plan or health  
13          care provider shall make the standard data elements  
14          transmitted or received by such plan or provider in  
15          connection with the transactions described in sub-  
16          sections (a), (b), and (c) or acquired under section  
17          11764(a) available for disclosure as authorized by  
18          this subtitle.

19           “(2) SPECIAL RULE.—In the case of a health  
20          care provider that does not file claims, such provider  
21          shall be responsible for making standard data ele-  
22          ments for encounter information available for disclo-  
23          sure as authorized by this subtitle.

24          “(e) SATISFACTION OF REQUIREMENTS.—A health  
25          care provider or health plan may satisfy the requirement

1 imposed on such provider or plan under subsection (a),  
 2 (b), (c), or (d) by—

3 “(1) directly transmitting standard data ele-  
 4 ments;

5 “(2) submitting nonstandard data elements to a  
 6 health information network service certified under  
 7 section 11741 for processing into standard data ele-  
 8 ments and transmission; or

9 “(3) in the case of a provider, submitting data  
 10 elements to a plan which satisfies the requirements  
 11 imposed on such provider on the provider’s behalf.

12 “(f) TIMELINESS.—A health care provider or health  
 13 plan shall be determined to have satisfied a requirement  
 14 imposed under this section only if the action required is  
 15 completed in a timely manner, as determined by the Sec-  
 16 retary. In setting standards for timeliness, the Secretary  
 17 shall take into consideration the age and the amount of  
 18 information being requested.

19 **“SEC. 11722. TIMETABLES FOR COMPLIANCE WITH RE-**  
 20 **QUIREMENTS.**

21 “(a) INITIAL COMPLIANCE.—

22 “(1) IN GENERAL.—Not later than 12 months  
 23 after the date on which standards are adopted under  
 24 part II with respect to a type of transaction or data  
 25 elements for a type of health information, a health

1 plan or health care provider shall comply with the  
2 requirements of this subtitle with respect to such  
3 transaction or information.

4 “(2) ADDITIONAL DATA ELEMENTS.—Not later  
5 than 12 months after the date on which the Sec-  
6 retary adopts an addition to a set of data elements  
7 for health information under part II, a health plan  
8 or health care provider shall comply with the re-  
9 quirements of this subtitle using such data elements.

10 “(b) COMPLIANCE WITH MODIFIED STANDARDS.—

11 “(1) IN GENERAL.—If the Secretary adopts a  
12 modified standard under part II, a health plan or  
13 health care provider shall be required to comply with  
14 the modified standard at such time as the Secretary  
15 determines appropriate taking into account the time  
16 needed to comply due to the nature and extent of  
17 the modification.

18 “(2) SPECIAL RULE.—In the case of modifica-  
19 tions to standards that do not occur within the 12-  
20 month period beginning on the date such standards  
21 are adopted, the time determined appropriate by the  
22 Secretary under paragraph (1) shall be no sooner  
23 than the last day of the 90-day period beginning on  
24 the date such modified standard is adopted and no

1 later than the last day of the 12 month period begin-  
2 ning on the date such modified standard is adopted.

3 **“PART IV—ACCESSING HEALTH INFORMATION**

4 **“SEC. 11731. ACCESSING HEALTH INFORMATION FOR AU-**  
5 **THORIZED PURPOSES.**

6 “(a) IN GENERAL.—The Secretary shall adopt tech-  
7 nical standards for appropriate persons, including health  
8 plans, health care providers, health information network  
9 services certified under section 11741, health researchers,  
10 and Federal and State agencies, to locate and access the  
11 health information that is available through the health in-  
12 formation network due to the requirements of this subtitle.  
13 Such technical standards shall ensure that any request to  
14 locate or access information shall be authorized under sub-  
15 title C.

16 “(b) PROCUREMENT RULE FOR GOVERNMENT AGEN-  
17 CIES.—

18 “(1) IN GENERAL.—Health information protec-  
19 tion organizations certified under section 11741  
20 shall make available to a Federal or State agency  
21 pursuant to a Federal Acquisition Regulation (or an  
22 equivalent State system), any non-identifiable health  
23 information that is requested by such agency.

24 “(2) CERTAIN INFORMATION AVAILABLE AT  
25 LOW COST.—If a health information protection orga-

1       nization described in paragraph (1) needs informa-  
2       tion from a health plan or health care provider in  
3       order to comply with a request of a Federal or State  
4       agency that is necessary to comply with a require-  
5       ment under this Act, such plan or provider shall  
6       make such information available to such organiza-  
7       tion for a charge that does not exceed the reasonable  
8       cost of transmitting the information. If requested, a  
9       health information protection organization that re-  
10      ceives information under the preceding sentence  
11      must make such information available to any other  
12      such organization that is certified under section  
13      11741 for a charge that does not exceed the reason-  
14      able cost of transmitting the information.

15      “(c) FUNCTIONAL SEPARATION.—The standards  
16      adopted by the Secretary under subsection (a) shall ensure  
17      that any health information disclosed under such sub-  
18      section shall not, after such disclosure, be used or released  
19      for an administrative, regulatory, or law enforcement pur-  
20      pose unless such disclosure was made for such purpose.

21      “(d) PUBLIC USE FUNCTIONS.—Nothing in this sub-  
22      title shall be construed to limit the authority of a Federal  
23      or State agency to make non-identifiable health informa-  
24      tion available for public use functions.



1 **“SEC. 11732. RESPONDING TO ACCESS REQUESTS.**

2 “(a) IN GENERAL.—The Secretary may adopt, and  
3 modify as appropriate, standards under which a health  
4 care provider or health plan shall respond to requests for  
5 access to health information consistent with this subtitle  
6 and subtitle C.

7 “(b) STANDARDS DESCRIBED.—The standards under  
8 subsection (a) shall provide—

9 “(1) for a standard format under which a pro-  
10 vider or plan will respond to each request either by  
11 satisfying the request or responding with an expla-  
12 nation of the specific restriction which results in a  
13 failure to satisfy the request; and

14 “(2) that any restrictions will not prevent a  
15 plan or provider from responding to a request in a  
16 timely manner taking into account the age and  
17 amount of the information being requested.

18 “(c) CONSTRUCTION.—Nothing in this section shall  
19 be construed as permitting a health care provider or health  
20 plan to refuse to disclose any health information that is  
21 required to be disclosed by law.

22 **“SEC. 11733. LENGTH OF TIME INFORMATION SHOULD BE**  
23 **ACCESSIBLE.**

24 “The Secretary shall adopt standards with respect to  
25 the length of time any standard data elements for a type

1 of health information should be accessible through the  
2 health information network.

3 **“SEC. 11734. TIMETABLES FOR ADOPTION OF STANDARDS**  
4 **AND COMPLIANCE.**

5 “(a) INITIAL STANDARDS.—The Secretary shall  
6 adopt standards under this part not later than 9 months  
7 after the date of the enactment of this subtitle and such  
8 standards shall be effective upon adoption.

9 “(b) MODIFICATIONS TO STANDARDS.—

10 “(1) IN GENERAL.—Except as provided in para-  
11 graph (2), the Secretary shall review the standards  
12 adopted under this part and shall adopt modified  
13 standards as determined appropriate, but no more  
14 frequently than once every 6 months. Any modifica-  
15 tion to standards shall be completed in a manner  
16 which minimizes the disruption and cost of compli-  
17 ance. Any modifications to standards adopted under  
18 this part shall be effective upon adoption.

19 “(2) SPECIAL RULE.—The Secretary shall not  
20 adopt modifications to any standards adopted under  
21 this part during the 12-month period beginning on  
22 the date such standards are adopted unless the Sec-  
23 retary determines that a modification is necessary in  
24 order to permit compliance with the requirements of  
25 this part.

1   **“PART V—STANDARDS AND CERTIFICATION FOR**  
2                   **HEALTH INFORMATION NETWORK**

3   **“SEC. 11741. STANDARDS AND CERTIFICATION FOR HEALTH**  
4                   **INFORMATION NETWORK SERVICES.**

5           “(a) STANDARDS FOR OPERATION.—The Secretary  
6 shall adopt standards with respect to the operation of  
7 health information network services to ensure that—

8                   “(1) such services cooperate with one another  
9           to form the health information network;

10                   “(2) such services meet all of the requirements  
11           under subtitle C that are applicable to such services;

12                   “(3) such services make public information con-  
13           cerning their performance, as measured by uniform  
14           indicators such as accessibility, transaction respon-  
15           siveness, administrative efficiency, reliability, de-  
16           pendability, and any other indicator determined ap-  
17           propriate by the Secretary;

18                   “(4) such services have security procedures that  
19           are consistent with the privacy requirements under  
20           subtitle C, including secure methods of access to and  
21           transmission of data;

22                   “(5) such services, if they are part of a larger  
23           organization, have policies and procedures in place  
24           which isolate their activities with respect to process-  
25           ing information in a manner that prevents unauthor-

1        ized access to such information by such larger orga-  
2        nization.

3        “(b) CERTIFICATION BY THE SECRETARY.—

4            “(1) ESTABLISHMENT.—Not later than 12  
5        months after the date of the enactment of this sub-  
6        title, the Secretary shall establish a certification pro-  
7        cedure for health information network services which  
8        ensures that certified services are qualified to meet  
9        the requirements of this subtitle and the standards  
10       established by the Secretary under this section. Such  
11       certification procedure shall be implemented in a  
12       manner that minimizes the costs and delays of oper-  
13       ations for such services.

14           “(2) APPLICATION.—Each entity desiring to be  
15        certified as a health information network service  
16        shall apply to the Secretary for certification in a  
17        form and manner determined appropriate by the  
18        Secretary.

19           “(3) AUDITS AND REPORTS.—The procedure  
20        established under paragraph (1) shall provide for au-  
21        dits by the Secretary and reports by an entity cer-  
22        tified under this section as the Secretary determines  
23        appropriate in order to monitor such entity’s compli-  
24        ance with the requirements of this subtitle, subtitle

1 C, and the standards established by the Secretary  
2 under this section.

3 “(c) LOSS OF CERTIFICATION.—

4 “(1) MANDATORY TERMINATION.—Except as  
5 provided in paragraph (3), if a health information  
6 network service violates a requirement imposed on  
7 such service under subtitle C, its certification under  
8 this section shall be terminated unless the Secretary  
9 determines that appropriate corrective action has  
10 been taken.

11 “(2) DISCRETIONARY TERMINATION.—If a  
12 health information network service violates a re-  
13 quirement or standard imposed under this subtitle  
14 and a penalty has been imposed under section  
15 11751, the Secretary shall review the certification of  
16 such service and may terminate such certification.

17 “(3) CONDITIONAL CERTIFICATION—The Sec-  
18 retary may establish a procedure under which a  
19 health information network service may remain cer-  
20 tified on a conditional basis if the service is operat-  
21 ing consistently with a plan intended to correct any  
22 violations described in paragraphs (1) or (2). Such  
23 procedure may provide for the appointment of a  
24 trustee to continue operation of the service until the  
25 requirements for full certification are met.

1       “(d) CERTIFICATION BY PRIVATE ENTITIES.—The  
2 Secretary shall designate private entities to conduct the  
3 certification procedures established by the Secretary under  
4 this section. A health information network service certified  
5 by such an entity in accordance with such designation  
6 shall be considered to be certified by the Secretary.

7       **“SEC. 11742. ENSURING AVAILABILITY OF INFORMATION.**

8       “The Secretary shall establish a procedure under  
9 which a health plan or health care provider which does  
10 not have the ability to transmit standard data elements  
11 directly or does not have access to a health information  
12 network service certified under section 11741 shall be able  
13 to make health information available for disclosure as au-  
14 thorized by this subtitle.

15                       **“PART VI—PENALTIES**

16       **“SEC. 11751. GENERAL PENALTY FOR FAILURE TO COMPLY**  
17                       **WITH REQUIREMENTS AND STANDARDS.**

18       “(a) IN GENERAL.—Except as provided in subsection  
19 (b), the Secretary shall impose on any person that violates  
20 a requirement or standard imposed under this subtitle a  
21 penalty of not more than \$1,000 for each violation. The  
22 provisions of section 1128A (other than subsections (a)  
23 and (b) and the second sentence of subsection (f)) shall  
24 apply to the imposition of a civil money penalty under this

1 subsection in the same manner as such provisions apply  
2 to the imposition of a penalty under section 1128A.

3 “(b) LIMITATIONS.—

4 “(1) NONCOMPLIANCE NOT DISCOVERED EXER-  
5 CISING REASONABLE DILIGENCE.—A penalty may  
6 not be imposed under subsection (a) if it is estab-  
7 lished to the satisfaction of the Secretary that the  
8 person liable for the penalty did not know, and by  
9 exercising reasonable diligence would not have  
10 known, that such person failed to comply with the  
11 requirement or standard described in subsection (a).

12 “(2) FAILURES DUE TO REASONABLE CAUSE.—

13 “(A) IN GENERAL.—Except as provided in  
14 subparagraphs (B) and (C), a penalty may not  
15 be imposed under subsection (a) if—

16 “(i) the failure to comply was due to  
17 reasonable cause and not to willful neglect;  
18 and

19 “(ii) the failure to comply is corrected  
20 during the 30-day period beginning on the  
21 1st date the person liable for the penalty  
22 knew, or by exercising reasonable diligence  
23 would have known, that the failure to com-  
24 ply occurred.

25 “(B) EXTENSION OF PERIOD.—

1           “(i) NO PENALTY.—The period re-  
2           ferred to in subparagraph (A)(ii) may be  
3           extended as determined appropriate by the  
4           Secretary based on the nature and extent  
5           of the failure to comply.

6           “(ii) ASSISTANCE.—If the Secretary  
7           determines that a health plan or health  
8           care provider failed to comply because such  
9           person was unable to comply, the Secretary  
10          may provide technical assistance to such  
11          person. Such assistance shall be provided  
12          in any manner determined appropriate by  
13          the Secretary.

14          “(3) REDUCTION.—In the case of a failure to  
15          comply which is due to reasonable cause and not to  
16          willful neglect, any penalty under subsection (a) that  
17          is not entirely waived under paragraph (2) may be  
18          waived to the extent that the payment of such pen-  
19          alty would be excessive relative to the compliance  
20          failure involved.

21          **“PART VII—MISCELLANEOUS PROVISIONS**

22          **“SEC. 11761. IMPOSITION OF ADDITIONAL REQUIREMENTS.**

23          “(a) DATA ELEMENT STANDARDS.—A person may  
24          not impose a standard on another person that is in addi-



1 tion to the standards adopted by the Secretary under sec-  
 2 tion 11712 unless—

3 “(1) such person voluntarily agrees to such  
 4 standard; or

5 “(2) a waiver is granted under subsection (c) to  
 6 impose such standard.

7 “(b) TRANSACTIONS AND ACCESS STANDARDS.—A  
 8 person may not impose a standard on another person that  
 9 is in addition to the standards adopted by the Secretary  
 10 under section 11713 or 11731 unless such person volun-  
 11 tarily agrees to such standard.

12 “(c) CONDITIONS FOR WAIVERS.—

13 “(1) IN GENERAL.—A person may request a  
 14 waiver from the Secretary in order to require an-  
 15 other person to comply with a standard that is in  
 16 addition to the standards adopted by the Secretary  
 17 under section 11712.

18 “(2) CONSIDERATION OF WAIVER REQUESTS.—  
 19 No waiver may be granted unless the Secretary de-  
 20 termines that the value of the data to be exchanged  
 21 for research or other purposes significantly out-  
 22 weighs the administrative cost of the additional  
 23 standard taking into consideration the burden of the  
 24 timing of the imposition of the additional standard.

1           “(3) ANONYMOUS REPORTING.—If a person at-  
2       tempts to impose a standard in addition to the  
3       standards adopted by the Secretary under section  
4       11712, the person on whom such additional stand-  
5       ard is being imposed may contact the Secretary. The  
6       Secretary shall develop a procedure under which the  
7       contacting person shall remain anonymous. The Sec-  
8       retary shall notify the person imposing the addi-  
9       tional standard that the additional standard may not  
10      be imposed unless the other person voluntarily  
11      agrees to such standard or a waiver is obtained  
12      under this subsection.

13   **“SEC. 11762. EFFECT ON STATE LAW.**

14           “(a) IN GENERAL.—A provision, requirement, or  
15      standard under this subtitle shall supersede any contrary  
16      provision of State law, including—

17           “(1) a provision of State law that requires med-  
18      ical or health plan records (including billing informa-  
19      tion) to be maintained or transmitted in written  
20      rather than electronic form, and

21           “(2) a provision of State law which provides for  
22      requirements or standards that are more stringent  
23      than the requirements or standards under this sub-  
24      title;

1 except where the Secretary determines that the provision  
2 is necessary to prevent fraud and abuse, with respect to  
3 controlled substances, or for other purposes.

4 “(b) PUBLIC HEALTH REPORTING.—Nothing in this  
5 subtitle shall be construed to invalidate or limit the au-  
6 thority, power, or procedures established under any law  
7 providing for the reporting of disease or injury, child  
8 abuse, birth, or death, public health surveillance, or public  
9 health investigation or intervention.

10 **“SEC. 11764. HEALTH INFORMATION CONTINUITY.**

11 “(a) INFORMATION HELD BY HEALTH PLANS AND  
12 PROVIDERS.—If a health plan or health care provider  
13 takes any action that would threaten the continued avail-  
14 ability of the standard data elements of health information  
15 held by such plan or provider, such data elements shall  
16 be obtained by the State in which such plan or provider  
17 is located. The State shall ensure that such data elements  
18 are transferred to a health plan or health care provider  
19 in accordance with procedures established by the Sec-  
20 retary.

21 “(b) INFORMATION HELD BY HEALTH INFORMATION  
22 NETWORK SERVICES.—If a health information network  
23 service certified under section 11741 loses its certified sta-  
24 tus or takes any action that would threaten the continued  
25 availability of the standard data elements of health infor-

1 mation held by such service, such data elements shall be  
2 transferred to another health information network service  
3 certified under section 11741, as designated by the Sec-  
4 retary.

5 **“SEC. 11765. PROTECTION OF COMMERCIAL INFORMATION.**

6 “In adopting standards under this subtitle, the Sec-  
7 retary shall not require disclosure of trade secrets and  
8 confidential commercial information by entities operating  
9 in the health information network except as required by  
10 law.

11 **“SEC. 11766. PAYMENT FOR HEALTH CARE SERVICES OR**  
12 **HEALTH PLAN PREMIUMS.**

13 “Nothing in this subtitle shall be construed to pro-  
14 hibit payments for health care services or health plan pre-  
15 miums from being made by debit, credit, or other payment  
16 cards or numbers or other electronic payment means.

17 **“SEC. 11767. HEALTH SECURITY CARDS.**

18 “The Secretary shall adopt standards relating to the  
19 form of any health security cards that a health plan may  
20 issue and the information to be encoded electronically on  
21 such cards.

22 **“SEC. 11768. AUTHORIZATION OF APPROPRIATIONS.**

23 “There are authorized to be appropriated such sums  
24 as may be necessary to carry out the purposes of this sub-  
25 title.

1     **“PART VIII—ASSISTANCE TO THE SECRETARY**

2     **“SEC. 11771. GENERAL REQUIREMENT ON SECRETARY.**

3         “In complying with any requirements imposed under  
4 this subtitle, the Secretary shall rely on recommendations  
5 of the Health Information Advisory Committee established  
6 under section 11772 and shall consult with appropriate  
7 Federal agencies.

8     **“SEC. 11772. HEALTH INFORMATION ADVISORY COMMIT-**  
9                     **TEE.**

10         “(a) ESTABLISHMENT.—There is established a com-  
11 mittee to be known as the Health Care Information Advi-  
12 sory Committee.

13         “(b) DUTY.—

14             “(1) IN GENERAL.—The committee shall—

15                 “(A) provide assistance to the Secretary in  
16 complying with the requirements imposed on  
17 the Secretary under this subtitle and subtitle C;

18                 “(B) be generally responsible for advising  
19 the Secretary and the Congress on the status of  
20 the health information network; and

21                 “(C) make recommendations to correct any  
22 problems that may occur in the network’s im-  
23 plementation and ongoing operations and to re-  
24 fine and improve the network.

25             “(2) TECHNICAL ASSISTANCE.—In performing  
26 its duties under this subsection, the committee shall

1 receive technical assistance from appropriate Federal  
2 agencies.

3 “(c) MEMBERSHIP.—

4 “(1) IN GENERAL.—The committee shall con-  
5 sist of 15 members to be appointed by the President  
6 not later than 60 days after the date of the enact-  
7 ment of this subtitle. The President shall designate  
8 1 member as the Chair.

9 “(2) EXPERTISE.—The membership of the com-  
10 mittee shall consist of individuals who are of recog-  
11 nized standing and distinction and who possess the  
12 demonstrated capacity to discharge the duties im-  
13 posed on the committee.

14 “(3) TERMS.—Each member of the committee  
15 shall be appointed for a term of 5 years, except that  
16 the members first appointed shall serve staggered  
17 terms such that the terms of no more than 3 mem-  
18 bers expire at one time.

19 “(4) VACANCIES.—

20 “(A) IN GENERAL.—A vacancy on the  
21 committee shall be filled in the manner in which  
22 the original appointment was made and shall be  
23 subject to any conditions which applied with re-  
24 spect to the original appointment.

1           “(B) FILLING UNEXPIRED TERM.—An in-  
2           dividual chosen to fill a vacancy shall be ap-  
3           pointed for the unexpired term of the member  
4           replaced.

5           “(C) EXPIRATION OF TERMS.—The term  
6           of any member shall not expire before the date  
7           on which the member’s successor takes office.

8           “(5) CONFLICTS OF INTEREST.—Members of  
9           the committee shall disclose upon appointment to  
10          the committee or at any subsequent time that it may  
11          occur, conflicts of interest.

12          “(d) MEETINGS.—

13               “(1) IN GENERAL.—Except as provided in para-  
14               graph (2), the committee shall meet at the call of  
15               the Chair.

16               “(2) INITIAL MEETING.—Not later than 30  
17               days after the date on which all members of the  
18               committee have been appointed, the committee shall  
19               hold its first meeting.

20               “(3) QUORUM.—A majority of the members of  
21               the committee shall constitute a quorum, but a less-  
22               er number of members may hold hearings.

23               “(e) POWER TO HOLD HEARINGS.—The committee  
24               may hold such hearings, sit and act at such times and  
25               places, take such testimony, and receive such evidence as

1 the committee considers advisable to carry out the pur-  
2 poses of this section.

3 “(f) OTHER ADMINISTRATIVE PROVISIONS.—Sub-  
4 paragraphs (C), (D), and (H) of section 1886(e)(6) shall  
5 apply to the committee in the same manner as they apply  
6 to the Prospective Payment Assessment Commission.

7 “(g) REPORTS.—

8 “(1) IN GENERAL.—The committee shall annu-  
9 ally prepare and submit to Congress and the Sec-  
10 retary a report including at least an analysis of—

11 “(A) the status of the health information  
12 network established under this subtitle, includ-  
13 ing whether the network is fulfilling the pur-  
14 pose described in section 11701;

15 “(B) the savings and costs of the network;

16 “(C) the activities of health information  
17 network services certified under section 11741,  
18 health care providers, health plans, and other  
19 entities using the network to exchange health  
20 information;

21 “(D) the extent to which entities described  
22 in subparagraph (C) are meeting the standards  
23 adopted under this subtitle and working to-  
24 gether to form an integrated network that  
25 meets the needs of its users;



1           “(E) the extent to which entities described  
2           in subparagraph (C) are meeting the privacy  
3           and security protections of subtitle C;

4           “(F) the number and types of penalties as-  
5           sessed for noncompliance with the standards  
6           adopted under this subtitle;

7           “(G) whether the Federal Government and  
8           State Governments are receiving information of  
9           sufficient quality to meet their responsibilities  
10          under the America’s Health Care Option Act;

11          “(H) any problems with respect to imple-  
12          mentation of the network;

13          “(I) the extent to which timetables under  
14          this subtitle for the adoption and implementa-  
15          tion of standards are being met; and

16          “(J) any legislative recommendations relat-  
17          ed to the health information network.

18          “(2) AVAILABILITY TO THE PUBLIC.—Any in-  
19          formation in the report submitted to Congress under  
20          paragraph (1) shall be made available to the public  
21          unless such information may not be disclosed by law.

22          “(h) DURATION.—Notwithstanding section 14(a) of  
23          the Federal Advisory Committee Act, the committee shall  
24          continue in existence until otherwise provided by law.

25          “(i) AUTHORIZATION OF APPROPRIATIONS.—

1           “(1) IN GENERAL.—There are authorized to be  
2       appropriated such sums as may be necessary to  
3       carry out the purposes of this section.

4           “(2) AVAILABILITY.—Any sums appropriated  
5       under the authorization contained in this subsection  
6       shall remain available, without fiscal year limitation,  
7       until expended.

8   **“PART IX—DEMONSTRATION PROJECTS FOR**  
9       **COMMUNITY-BASED CLINICAL INFORMATION**  
10      **SYSTEMS**

11   **“SEC. 11781. GRANTS FOR DEMONSTRATION PROJECTS.**

12       “(a) IN GENERAL.—The Secretary may make grants  
13   for demonstration projects to promote the development  
14   and use of electronically integrated community-based clinical  
15   information systems and computerized patient medical  
16   records.

17       “(b) APPLICATIONS.—

18           “(1) SUBMISSION.—To apply for a grant under  
19   this part for any fiscal year, an applicant shall submit  
20   an application to the Secretary in accordance  
21   with the procedures established by the Secretary.

22           “(2) CRITERIA FOR APPROVAL.—The Secretary  
23   may not approve an application submitted under  
24   paragraph (1) unless the application includes assur-

ances satisfactory to the Secretary regarding the following:

“(A) USE OF EXISTING TECHNOLOGY.—

Funds received under this part will be used to apply telecommunications and information systems technology that is in existence on the date the application is submitted in a manner that improves the quality of health care, reduces the costs of such care, and protects the privacy and confidentiality of information relating to the physical or mental condition of an individual.

“(B) USE OF EXISTING INFORMATION SYS-

TEMS.—Funds received under this part will be used—

“(i) to enhance telecommunications or information systems that are operating on the date the application is submitted;

“(ii) to integrate telecommunications or information systems that are operating on the date the application is submitted; or

“(iii) to connect additional users to telecommunications or information networks or systems that are operating on the date the application is submitted.

1           “(C) MATCHING FUNDS.—The applicant  
2           shall make available funds for the demonstra-  
3           tion project in an amount that equals at least  
4           20 percent of the cost of the project.

5           “(c) GEOGRAPHIC DIVERSITY.—In making any  
6           grants under this part, the Secretary shall, to the extent  
7           practicable, make grants to persons representing different  
8           geographic areas of the United States, including urban  
9           and rural areas.

10          “(d) REVIEW AND SANCTIONS.—The Secretary shall  
11          review at least annually the compliance of a person receiv-  
12          ing a grant under this part with the provisions of this  
13          part. The Secretary shall establish a procedure for deter-  
14          mining whether such a person has failed to comply sub-  
15          stantially within the provisions of this part and the sanc-  
16          tions to be imposed for any such noncompliance.

17          “(e) ANNUAL REPORT.—The Secretary shall submit  
18          an annual report to the President for transmittal to Con-  
19          gress containing a description of the activities carried out  
20          under this part.

21          “(g) AUTHORIZATION OF APPROPRIATIONS.—There  
22          are authorized to be appropriated such sums as may be  
23          necessary to carry out the purposes of this section.”.

24                 (2) Conforming amendments.—(A) Title XI of  
25          the Social Security Act (42 U.S.C. 1301 et seq.) is

1 amended by striking the title and inserting the fol-  
 2 lowing:

3 **“TITLE XI—GENERAL PROVI-**  
 4 **SIONS, PEER REVIEW, AND**  
 5 **ADMINISTRATIVE SIM-**  
 6 **PLIFICATION**

7 **“Subtitle A—General Provisions**  
 8 **and Peer Review”**

9 (B) Title XI of the Social Security Act (42  
 10 U.S.C. 1301 et seq.) is amended by striking each  
 11 reference to “this title” and inserting “this subtitle”.

12 (b) MEDICARE AND MEDICAID COVERAGE DATA  
 13 BANK AND RELATED IDENTIFICATION PROCESSES.—

14 (1) DELAY OF EMPLOYER REPORTING RE-  
 15 QUIREMENT.—

16 (A) IN GENERAL.—Section 1144(c)(1)(A)  
 17 of the Social Security Act (42 U.S.C. 1320–  
 18 14(c)(1)(A)) is amended by striking “January  
 19 1, 1994” and inserting “January 1, 1996”.

20 (B) EFFECTIVE DATE.—The amendment  
 21 made by this paragraph shall be effective on the  
 22 date of the enactment of this Act.

23 (2) REPEAL OF DATA BANK.—

24 (A) IN GENERAL.—Section 1144 of the So-  
 25 cial Security Act (42 U.S.C. 1320b–14) and

1 section 101(f) of the Employee Retirement In-  
2 come Security Act of 1974 (29 U.S.C. 1021(f))  
3 are repealed.

4 (B) INTERNAL REVENUE CODE PROVI-  
5 SION.—Section 6103(*l*) of the Internal Revenue  
6 Code of 1986 is amended by striking paragraph  
7 (12).

8 (C) IDENTIFICATION OF MEDICARE SEC-  
9 ONDARY PAYER SITUATIONS.—Section 1862(b)  
10 of the Social Security Act (42 U.S.C. 1395y(b))  
11 is amended by striking paragraph (5).

12 (D) CONFORMING AMENDMENTS.—(i) Sec-  
13 tion 1902(a)(25)(A)(i) of the Social Security  
14 Act (42 U.S.C. 1396a(a)(25)(A)(i)) is amended  
15 by striking “including the use of information  
16 collected by the Medicare and Medicaid Cov-  
17 erage Data Bank under section 1144 and any  
18 additional measures”.

19 (ii) Subsection (a)(8)(B) of section 552a of  
20 title 5, United States Code, is amended—

21 (I) in clause (v), by inserting “; or” at  
22 the end;

23 (II) in clause (vi), by striking “or” at  
24 the end; and

25 (III) by striking clause (vii).

1 (E) EFFECTIVE DATE.—The amendments  
 2 made by this paragraph apply after the date on  
 3 which the health information network estab-  
 4 lished under subsection (a) is capable of replac-  
 5 ing the activities performed under the provi-  
 6 sions affected by such amendments, as certified  
 7 by the Secretary of Health and Human Serv-  
 8 ices.

9 **SEC. 602. PRIVACY OF HEALTH INFORMATION UNDER THE**  
 10 **SOCIAL SECURITY ACT.**

11 (a) IN GENERAL.—Title XI of the Social Security Act  
 12 (42 U.S.C. 1301 et seq.), as amended by section 601, is  
 13 amended by adding at the end the following new subtitle:

14 **“Subtitle C—Privacy of Health**  
 15 **Information**

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“Subtitle C—Privacy of Health Information

“PART I—FINDINGS AND DEFINITIONS

“Sec. 11801. Findings and purposes.

“Sec. 11802. Definitions.

“PART II—AUTHORIZED DISCLOSURES

“SUBPART A—GENERAL PROVISIONS

“Sec. 11811. General rules regarding disclosure.

“Sec. 11812. Authorizations for disclosure of protected health information.

“Sec. 11813. Certified health information network services.

“SUBPART B—SPECIFIC DISCLOSURES RELATING TO PATIENT

“Sec. 11821. Disclosures for treatment and financial and administrative transactions.

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“SUBPART C—DISCLOSURE FOR OVERSIGHT, PUBLIC HEALTH, AND RESEARCH PURPOSES

- “Sec. 11831. Oversight.
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“SUBPART D—DISCLOSURE FOR JUDICIAL, ADMINISTRATIVE, AND LAW ENFORCEMENT PURPOSES

- “Sec. 11841. Judicial and administrative purposes.
- “Sec. 11842. Law enforcement.

“SUBPART E—DISCLOSURE PURSUANT TO GOVERNMENT SUBPOENA OR WARRANT

- “Sec. 11851. Government subpoenas and warrants.
- “Sec. 11852. Access procedures for law enforcement subpoenas and warrants.
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“SUBPART F—DISCLOSURE PURSUANT TO PRIVATE PARTY SUBPOENA

- “Sec. 11854. Private party subpoenas.
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“PART III—PROCEDURES FOR ENSURING SECURITY OF PROTECTED HEALTH INFORMATION

“SUBPART A—ESTABLISHMENT OF SAFEGUARDS

- “Sec. 11861. Establishment of safeguards.
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- “Sec. 11871. Inspection of protected health information.
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“SUBPART C—STANDARDS FOR ELECTRONIC DISCLOSURES

- “Sec. 11882. Standards for electronic disclosures.

“PART IV—SANCTIONS

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- “Sec. 11891. No liability for permissible disclosures.
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- “Sec. 11893. Reliance on certified entity.

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## “SUBPART C—CRIMINAL SANCTIONS

“Sec. 11911. Wrongful disclosure of protected health information.

## “PART V—ADMINISTRATIVE PROVISIONS

“Sec. 11921. Relationship to other laws.

“Sec. 11922. Rights of incompetents.

“Sec. 11923. Exercise of rights.

1           **“PART I—FINDINGS AND DEFINITIONS**

2           **“SEC. 11801. FINDINGS AND PURPOSES.**

3           “(a) FINDINGS.—The Congress finds as follows:

4               “(1) The improper disclosure of individually  
5               identifiable health care information may cause sig-  
6               nificant harm to an individual’s interests in privacy,  
7               health care, and reputation and may unfairly affect  
8               the ability of an individual to obtain employment,  
9               education, insurance, and credit.

10               “(2) The movement of people and health care  
11               related information across State lines, the availabil-  
12               ity of, access to, and exchange of health care related  
13               information with Federally funded health care sys-  
14               tems, the medicare program under title XVIII, and  
15               the medicaid program under title XIX, through  
16               automated data banks and networks, and the emer-  
17               gence of other multistate health care providers and  
18               payors create a need for a uniform Federal law gov-  
19               erning the disclosure of health care information.

20               “(b) PURPOSE.—The purpose of this subtitle is to es-  
21               tablish effective mechanisms to protect the privacy of indi-

1 viduals with respect to individually identifiable health care  
 2 information that is created or maintained as part of health  
 3 treatment, enrollment, payment, testing, or research proc-  
 4 esses.

5 **“SEC. 11802. DEFINITIONS.**

6       “(a) TERMS RELATING TO PROTECTED HEALTH IN-  
 7 FORMATION.—In this subtitle:

8               “(1) PROTECTED HEALTH INFORMATION.—The  
 9       term ‘protected health information’ means any infor-  
 10       mation, including demographic information collected  
 11       from an individual, whether oral or recorded in any  
 12       form or medium, that—

13               “(A) is created or received by a health care  
 14       provider, health plan, health oversight agency,  
 15       health researcher, public health authority, em-  
 16       ployer, life insurer, school or university, or cer-  
 17       tified health information network service; and

18               “(B) relates to the past, present, or future  
 19       physical or mental health or condition of an in-  
 20       dividual, the provision of health care to an indi-  
 21       vidual, or the past, present, or future payment  
 22       for the provision of health care to an individual,  
 23       and—

24               “(i) identifies an individual; or

1                   “(ii) with respect to which there is a  
2                   reasonable basis to believe that the infor-  
3                   mation can be used to identify an individ-  
4                   ual.

5                   “(2) DISCLOSE.—The term ‘disclose’, when  
6                   used with respect to protected health information,  
7                   means to provide access to the information, but only  
8                   if such access is provided to a person other than the  
9                   individual who is the subject of the information.

10                  “(b) TERMS RELATING TO HEALTH CARE SYSTEM  
11 PARTICIPANTS.—In this subtitle:

12                   “(1) HEALTH INFORMATION TRUSTEE.—The  
13                   term ‘health information trustee’ means—

14                   “(A) a health care provider, health plan,  
15                   health oversight agency, certified health infor-  
16                   mation network service, employer, life insurer,  
17                   or school or university insofar as it creates, re-  
18                   ceives, maintains, uses, or transmits protected  
19                   health information;

20                   “(B) any person who obtains protected  
21                   health information under section 11823, 11832,  
22                   11833, 11841, 11842, 11851, or 11854; and

23                   “(C) any employee or agent of a person  
24                   covered under subparagraphs (A) or (B).

25                   “(2) HEALTH CARE.—The term ‘health care’—

1 “(A) means—

2 “(i) a preventative, diagnostic, thera-  
3 peutic, rehabilitative, maintenance, or pal-  
4 liative care, counseling, service, or proce-  
5 dure—

6 “(I) with respect to the physical  
7 or mental condition of an individual;  
8 or

9 “(II) affecting the structure or  
10 function of the human body or any  
11 part of the human body; or

12 “(ii) any sale or dispensing of a drug,  
13 device, equipment, or other item to an indi-  
14 vidual, or for the use of an individual, pur-  
15 suant to a prescription; but

16 “(B) does not include any item or service  
17 that is not furnished for the purpose of examin-  
18 ing, maintaining, or improving the health of an  
19 individual.

20 “(3) HEALTH CARE PROVIDER.—The term  
21 ‘health care provider’ means a person who is li-  
22 censed, certified, registered, or otherwise authorized  
23 by law to provide an item or service that constitutes  
24 health care in the ordinary course of business or  
25 practice of a profession.

1           “(4) HEALTH OVERSIGHT AGENCY.—The term  
2       ‘health oversight agency’ means a person who—

3           “(A) performs or oversees the performance  
4       of an assessment, evaluation, determination, or  
5       investigation relating to the licensing, accredita-  
6       tion, or certification of health care  
7       providers; or

8           “(B)(i) performs or oversees the perform-  
9       ance of an assessment, evaluation, determina-  
10      tion, or investigation relating to the effective-  
11      ness of, compliance with, or applicability of  
12      legal, fiscal, medical, or scientific standards or  
13      aspects of performance related to the delivery  
14      of, or payment for, health care or relating to  
15      health care fraud or fraudulent claims for pay-  
16      ment regarding health; and

17          “(ii) is a public agency, acting on behalf of  
18      a public agency, acting pursuant to a require-  
19      ment of a public agency, or carrying out activi-  
20      ties under a Federal or State law governing the  
21      assessment, evaluation, determination, or inves-  
22      tigation described in clause (i).

23          “(5) HEALTH PLAN.—The term ‘health plan’  
24      shall have the meaning given such term under sec-  
25      tion 11702.

1           “(6) HEALTH RESEARCHER.—The term ‘health  
2       researcher’ means a person who conducts a bio-  
3       medical, public health, epidemiological, health serv-  
4       ices, or health statistics research project or a re-  
5       search project on social and behavioral factors relat-  
6       ing to health.

7           “(7) INSTITUTIONAL REVIEW BOARD.—The  
8       term ‘institutional review board’ means—

9           “(A) a board established in accordance  
10       with regulations of the Secretary under section  
11       491(a) of the Public Health Service Act;

12          “(B) a similar board established by the  
13       Secretary for the protection of human subjects  
14       in research conducted by the Secretary; or

15          “(C) a similar board established under reg-  
16       ulations of a Federal Government authority  
17       other than the Secretary.

18          “(8) PUBLIC HEALTH AUTHORITY.—The term  
19       ‘public health authority’ means an authority or in-  
20       strumentality of the United States, a State, or a po-  
21       litical subdivision of a State that is (A) responsible  
22       for public health matters; and (B) engaged in such  
23       activities as injury reporting, public health surveil-  
24       lance, and public health investigation or interven-  
25       tion.

1       “(c) REFERENCES TO CERTIFIED ENTITIES.—In this  
2 subtitle:

3           “(1) CERTIFIED HEALTH INFORMATION NET-  
4 WORK SERVICE.—The term ‘certified health informa-  
5 tion network service’ means a health information  
6 service (as defined under section 11702) that is cer-  
7 tified under section 11741.

8           “(2) CERTIFIED HEALTH INFORMATION PRO-  
9 TECTION ORGANIZATION.—The term ‘certified health  
10 information protection organization’ means a health  
11 information protection organization (as defined in  
12 section 11702) that is certified under section 11741.

13       “(d) OTHER TERMS.—In this subtitle:

14           “(1) INDIVIDUAL REPRESENTATIVE.—The term  
15 ‘individual representative’ means any individual le-  
16 gally empowered to make decisions concerning the  
17 provision of health care to an individual (where the  
18 individual lacks the legal capacity under State law to  
19 make such decisions) or the administrator or execu-  
20 tor of the estate of a deceased individual.

21           “(2) LAW ENFORCEMENT INQUIRY.—The term  
22 ‘law enforcement inquiry’ means an investigation or  
23 official proceeding inquiring into whether there is a  
24 violation of, or failure to comply with, any criminal

1 or civil statute or any regulation, rule, or order is-  
2 sued pursuant to such a statute.

3 “(3) PERSON.—The term ‘person’ includes an  
4 authority of the United States, a State, or a political  
5 subdivision of a State.

6 **“PART II—AUTHORIZED DISCLOSURES**

7 **“Subpart A—General Provisions**

8 **“SEC. 11811. GENERAL RULES REGARDING DISCLOSURE.**

9 “(a) GENERAL RULE.—A health information trustee  
10 may disclose protected health information only for a pur-  
11 pose that is authorized under this subtitle.

12 “(b) DISCLOSURE WITHIN A TRUSTEE.—A health in-  
13 formation trustee may disclose protected health informa-  
14 tion to an officer, employee, or agent of the trustee, but  
15 only for a purpose that is compatible with and related to  
16 the purpose for which the information was collected or re-  
17 ceived by that trustee.

18 “(c) SCOPE OF DISCLOSURE.—

19 “(1) IN GENERAL.—Every disclosure of pro-  
20 tected health information by a health information  
21 trustee shall be limited to the minimum amount of  
22 information necessary to accomplish the purpose for  
23 which the information is disclosed.

24 “(2) REGULATIONS.—The Secretary, after no-  
25 tice and opportunity for public comment, may issue



1 regulations under paragraph (1), which shall take  
2 into account the technical capabilities of the record  
3 systems used to maintain protected health informa-  
4 tion and the costs of limiting disclosure.

5 “(d) NO GENERAL REQUIREMENT TO DISCLOSE.—  
6 Nothing in this subtitle that permits a disclosure of health  
7 information shall be construed to require such disclosure.

8 “(e) USE AND REDISCLOSURE OF INFORMATION.—  
9 The protected health information received under a disclo-  
10 sure permitted by the subtitle may not be used or disclosed  
11 unless the use or disclosure is necessary to fulfill the pur-  
12 pose for which the information was obtained and is not  
13 otherwise prohibited by law. Protected health information  
14 about an individual that is disclosed under this subtitle  
15 may not be used in, or disclosed to any person for use  
16 in, any administrative, civil, or criminal action or inves-  
17 tigation directed against the individual unless specifically  
18 permitted by this subtitle.

19 “(f) IDENTIFICATION OF DISCLOSED INFORMATION  
20 AS PROTECTED INFORMATION.—

21 “(1) IN GENERAL.—Except with respect to pro-  
22 tected health information that is disclosed under sec-  
23 tion 11823 and except as provided in paragraph (2),  
24 a health information trustee may not disclose pro-  
25 tected health information unless such information is

1 clearly identified as protected health information  
2 that is subject to this subtitle.

3 “(2) ROUTINE DISCLOSURES SUBJECT TO WRIT-  
4 TEN AGREEMENT.—A health information trustee  
5 who routinely discloses protected health information  
6 to a person may satisfy the identification require-  
7 ment in paragraph (1) through a written agreement  
8 between the trustee and the person with respect to  
9 the protected health information.

10 “(g) CONSTRUCTION.—Nothing in this subtitle shall  
11 be construed to limit the ability of a health information  
12 trustee to charge a reasonable fee for the disclosure or  
13 reproduction of health information.

14 “(h) INFORMATION IN WHICH PROVIDERS ARE IDEN-  
15 TIFIED.—The Secretary, after notice and opportunity for  
16 public comment, may issue regulations protecting informa-  
17 tion identifying providers in order to promote the availabil-  
18 ity of health care services.

19 **“SEC. 11812. AUTHORIZATIONS FOR DISCLOSURE OF PRO-**  
20 **TECTED HEALTH INFORMATION.**

21 “(a) WRITTEN AUTHORIZATIONS.—A health infor-  
22 mation trustee may disclose protected health information  
23 pursuant to an authorization executed by the individual  
24 who is the subject of the information, if each of the follow-  
25 ing requirements is met:

1           “(1) WRITING.—The authorization is in writ-  
2           ing, signed by the individual who is the subject of  
3           the information, and dated on the date of such sig-  
4           nature.

5           “(2) SEPARATE FORM.—The authorization is  
6           not on a form used to authorize or facilitate the pro-  
7           vision of, or payment for, health care.

8           “(3) TRUSTEE DESCRIBED.—The trustee is  
9           specifically named or generically described in the au-  
10          thorization as authorized to disclose such informa-  
11          tion.

12          “(4) RECIPIENT DESCRIBED.—The person to  
13          whom the information is to be disclosed is specifi-  
14          cally named or generically described in the author-  
15          ization as a person to whom such information may  
16          be disclosed.

17          “(5) STATEMENT OF INTENDED DISCLO-  
18          SURES.—The authorization contains an acknowledg-  
19          ment that the individual who is the subject of the in-  
20          formation has read a statement of the disclosures  
21          that the person to receive the protected health infor-  
22          mation intends to make, which statement shall be in  
23          writing, on a form that is distinct from the author-  
24          ization for disclosure, and which statement must be

1 received by the individual authorizing the disclosure  
2 on or before such authorization is executed.

3 “(6) INFORMATION DESCRIBED.—The informa-  
4 tion to be disclosed is described in the authorization.

5 “(7) EXPIRATION DATE SPECIFIED.—The au-  
6 thorization specifies a date or event upon which the  
7 authorization expires, which shall not exceed 2 years  
8 from the date of the execution of the authorization.

9 “(8) AUTHORIZATION TIMELY RECEIVED.—The  
10 authorization is received by the trustee during a pe-  
11 riod described in subsection (b)(1).

12 “(9) DISCLOSURE TIMELY MADE.—The disclo-  
13 sure occurs during a period described in subsection  
14 (b)(2).

15 “(b) TIME LIMITATIONS ON AUTHORIZATIONS.—

16 “(1) RECEIPT BY TRUSTEE.—For purposes of  
17 subsection (a)(8), an authorization is timely received  
18 if it is received by the trustee during—

19 “(A) the 1-year period beginning on the  
20 date on which the authorization is signed under  
21 subsection (a)(1), if the authorization permits  
22 the disclosure of protected health information to  
23 a person who provides health counseling or so-  
24 cial services to individuals; or

1           “(B) the 30-day period beginning on the  
2           date on which the authorization is signed under  
3           subsection (a)(1), if the authorization permits  
4           the disclosure of protected health information to  
5           a person other than a person described in sub-  
6           paragraph (A).

7           “(2) DISCLOSURE BY TRUSTEE.—For purposes  
8           of subsection (a)(9), a disclosure is timely made if  
9           it occurs before the date or event specified in the au-  
10          thorization upon which the authorization expires.

11          “(c) REVOCATION OR AMENDMENT OF AUTHORIZA-  
12          TION.—

13           “(1) IN GENERAL.—An individual may in writ-  
14          ing revoke or amend an authorization described in  
15          subsection (a), in whole or in part, at any time, ex-  
16          cept when—

17           “(A) disclosure of protected health infor-  
18          mation has been authorized to permit validation  
19          of expenditures for health care; or

20           “(B) action has been taken in reliance on  
21          the authorization.

22           “(2) NOTICE OF REVOCATION.—A health infor-  
23          mation trustee who discloses protected health infor-  
24          mation pursuant to an authorization that has been

1        revoked shall not be subject to any liability or pen-  
2        alty under this subtitle if—

3                “(A) the reliance was in good faith;

4                “(B) the trustee had no notice of the rev-  
5        ocation; and

6                “(C) the disclosure was otherwise in ac-  
7        cordance with the requirements of this subtitle.

8        “(d) DECEASED INDIVIDUAL.—The Secretary shall  
9        develop and establish through regulation a procedure for  
10       obtaining protected health information relating to a de-  
11       ceased individual when there is no individual representa-  
12       tive for such individual.

13       “(e) MODEL AUTHORIZATIONS.—The Secretary,  
14       after notice and opportunity for public comment, shall de-  
15       velop and disseminate model written authorizations of the  
16       type described in subsection (a) and model statements of  
17       intended disclosures of the type described in subsection  
18       (a)(5).

19       “(f) COPY.—A health information trustee who dis-  
20       closes protected health information pursuant to an author-  
21       ization under this section shall maintain a copy of the au-  
22       thorization.

1 **“SEC. 11813. CERTIFIED HEALTH INFORMATION NETWORK**  
2 **SERVICES.**

3 “(a) IN GENERAL.—A health information trustee  
4 may disclose protected health information to a certified  
5 health information network service acting as an agent of  
6 the trustee for any purpose permitted by this subtitle.  
7 Such a service, acting as an agent of a trustee, may dis-  
8 close protected health information to another person as  
9 permitted under this subtitle to facilitate the completion  
10 of the purpose for which such information was disclosed  
11 to the service.

12 “(b) CERTIFIED HEALTH INFORMATION PROTEC-  
13 TION ORGANIZATIONS.—A health information trustee may  
14 disclose protected health information to a certified health  
15 information protection organization for the purpose of cre-  
16 ating non-identifiable health information (as defined in  
17 section 11702).

18 **“Subpart B—Specific Disclosures Relating to Patient**  
19 **“SEC. 11821. DISCLOSURES FOR TREATMENT AND FINAN-**  
20 **CIAL AND ADMINISTRATIVE TRANSACTIONS.**

21 “(a) HEALTH CARE TREATMENT.—A health care  
22 provider, health plan, employer, or person who receives  
23 protected health information under section 11823, may  
24 disclose protected health information to a health care pro-  
25 vider for the purpose of providing health care to an indi-  
26 vidual if the individual who is the subject of the informa-

1 tion has not previously objected in writing to the disclo-  
2 sure.

3 “(b) DISCLOSURE TO HEALTH PLANS FOR FINAN-  
4 CIAL AND ADMINISTRATIVE PURPOSES.—A health care  
5 provider or employer may disclose protected health infor-  
6 mation to a health plan for the purpose of providing for  
7 the payment for, or reviewing the payment of, health care  
8 furnished to an individual.

9 “(c) DISCLOSURE BY HEALTH PLANS FOR FINAN-  
10 CIAL AND ADMINISTRATIVE PURPOSES.—A health plan  
11 may disclose protected health information to a health care  
12 provider or a health plan for the purpose of providing for  
13 the payment for, or reviewing the payment of, health care  
14 furnished to an individual.

15 **“SEC. 11822. NEXT OF KIN AND DIRECTORY INFORMATION.**

16 “(a) NEXT OF KIN.—A health care provider or per-  
17 son who receives protected health information under sec-  
18 tion 11823 may disclose protected health information to  
19 the next of kin, an individual representative of the individ-  
20 ual who is the subject of the information, or an individual  
21 with whom that individual has a close personal relation-  
22 ship if—

23 “(1) the individual who is the subject of the in-  
24 formation—



1           “(A) has been notified of the individual’s  
2           right to object and has not objected to the dis-  
3           closure;

4           “(B) is not competent to be notified about  
5           the right to object; or

6           “(C) exigent circumstances exist such that  
7           it would not be practicable to notify the individ-  
8           ual of the right to object; and

9           “(2) the information disclosed relates to health  
10          care currently being provided to that individual.

11          “(b) DIRECTORY INFORMATION.—A health care pro-  
12          vider and a person receiving protected health information  
13          under section 11823 may disclose protected health infor-  
14          mation to any person if—

15               “(1) the information does not reveal specific in-  
16               formation about the physical or mental condition of  
17               the individual who is the subject of the information  
18               or health care provided to that person;

19               “(2) the individual who is the subject of the in-  
20               formation—

21                       “(A) has been notified of the individual’s  
22                       right to object and has not objected to the dis-  
23                       closure;

24                       “(B) is not competent to be notified about  
25                       the right to object; or

1           “(C) exigent circumstances exist such that  
 2           it would not be practicable to notify the individ-  
 3           ual of the right to object; and

4           “(3) the information consists only of 1 or more  
 5           of the following items:

6           “(A) The name of the individual who is the  
 7           subject of the information.

8           “(B) If the individual who is the subject of  
 9           the information is receiving health care from a  
 10          health care provider on a premises controlled by  
 11          the provider—

12                  “(i) the location of the individual on  
 13                  the premises; and

14                  “(ii) the general health status of the  
 15                  individual, described as critical, poor, fair,  
 16                  stable, or satisfactory or in terms denoting  
 17                  similar conditions.

18          “(d) IDENTIFICATION OF DECEASED INDIVIDUAL.—  
 19          A health care provider, health plan, employer, or life in-  
 20          surer, may disclose protected health information if nec-  
 21          essary to assist in the identification of a deceased individ-  
 22          ual.

23          **“SEC. 11823. EMERGENCY CIRCUMSTANCES.**

24          “(a) IN GENERAL.—A health care provider, health  
 25          plan, employer, or person who receives protected health

1 information under this section may disclose protected  
2 health information in emergency circumstances when nec-  
3 essary to protect the health or safety of an individual from  
4 imminent harm.

5 “(b) SCOPE OF DISCLOSURE.—The disclosure of pro-  
6 tected health information under this section shall be lim-  
7 ited to persons who need the information to take action  
8 to protect the health or safety of the individual.

9 **“Subpart C—Disclosure for Oversight, Public Health,**  
10 **and Research Purposes**

11 **“SEC. 11831. OVERSIGHT.**

12 “(a) IN GENERAL.—A health information trustee  
13 may disclose protected health information to a health over-  
14 sight agency for an oversight function authorized by law.

15 “(b) USE IN ACTION AGAINST INDIVIDUALS.—Not-  
16 withstanding section 11811(e), protected health informa-  
17 tion about an individual that is disclosed under this sec-  
18 tion may be used in, or disclosed to any person for use  
19 in, any administrative, civil, or criminal action or inves-  
20 tigation directed against the individual who is the subject  
21 of the information if the action or investigation arises out  
22 of and is directly related to receipt of health care or pay-  
23 ment for health care or an action involving a fraudulent  
24 claim related to health.

1 **“SEC. 11832. PUBLIC HEALTH.**

2 “A health care provider, health plan, public health  
3 authority, employer, or person who receives protected  
4 health information under section 11823 may disclose pro-  
5 tected health information to a public health authority or  
6 other person authorized by law for use in a legally author-  
7 ized—

8 “(1) disease or injury reporting;

9 “(2) public health surveillance; or

10 “(3) public health investigation or intervention.

11 **“SEC. 11833. HEALTH RESEARCH.**

12 “(a) IN GENERAL.—A health information trustee  
13 may disclose protected health information to a health re-  
14 searcher if an institutional review board determines that  
15 the research project engaged in by the health researcher—

16 “(1) requires use of the protected health infor-  
17 mation for the effectiveness of the project; and

18 “(2) is of sufficient importance to outweigh the  
19 intrusion into the privacy of the individual who is  
20 the subject of the information that would result from  
21 the disclosure.

22 “(b) RESEARCH REQUIRING DIRECT CONTACT.—A  
23 health information trustee may disclose protected health  
24 information to a health researcher for a research project  
25 that includes direct contact with an individual who is the

1 subject of protected health information if an institutional  
2 review board determines that—

3 “(1) the research project meets the require-  
4 ments of paragraphs (1) and (2) of subsection (a);

5 “(2) direct contact is necessary to accomplish  
6 the research purpose; and

7 “(3) the direct contact will be made in a man-  
8 ner that minimizes the risk of harm, embarrassment,  
9 or other adverse consequences to the individual.

10 “(c) USE OF HEALTH INFORMATION NETWORK.—

11 “(1) IN GENERAL.—A health information trust-  
12 ee may disclose protected health information to a  
13 health researcher using the health information net-  
14 work (as defined in section 11702) only if an institu-  
15 tional review board certified by the Secretary under  
16 paragraph (2) determines that the research project  
17 engaged in by the health researcher meets the re-  
18 quirements of this section.

19 “(2) CERTIFICATION OF INSTITUTIONAL RE-  
20 VIEW BOARDS.—

21 “(A) REGULATIONS.—The Secretary, after  
22 notice and opportunity for public comment,  
23 shall issue regulations establishing certification  
24 requirements for institutional review boards  
25 under this subtitle. Such regulations shall be

1           based on regulations issued under section  
2           491(a) of the Public Health Service Act and  
3           shall ensure that institutional review boards  
4           certified under this paragraph have the quali-  
5           fications to access and protect the confidential-  
6           ity of research subjects.

7           “(B) CERTIFICATION.—The Secretary  
8           shall certify an institutional review board that  
9           meets the certification requirements established  
10          by the Secretary under subparagraph (A).

11       “(d) OBLIGATIONS OF RECIPIENT.—A person who  
12       receives protected health information pursuant to sub-  
13       section (a)—

14           “(1) shall remove or destroy, at the earliest op-  
15       portunity consistent with the purposes of the project,  
16       information that would enable an individual to be  
17       identified, unless—

18           “(A) an institutional review board has de-  
19       termined that there is a health or research jus-  
20       tification for retention of such identifiers; and

21           “(B) there is an adequate plan to protect  
22       the identifiers from disclosure that is inconsis-  
23       tent with this section; and

1           “(2) shall use protected health information sole-  
2       ly for purposes of the health research project for  
3       which disclosure was authorized under this section.

4   **“Subpart D—Disclosure For Judicial, Administrative,**  
5                   **and Law Enforcement Purposes**

6   **“SEC. 11841. JUDICIAL AND ADMINISTRATIVE PURPOSES.**

7       A health care provider, health plan, health oversight  
8   agency, or employer may disclose protected health infor-  
9   mation—

10           “(1) pursuant to the Federal Rules of Civil  
11       Procedure, the Federal Rules of Criminal Procedure,  
12       or comparable rules of other courts or administrative  
13       agencies in connection with litigation or proceedings  
14       to which the individual who is the subject of the in-  
15       formation is a party and in which the individual has  
16       placed the individual’s physical or mental condition  
17       in issue;

18           “(2) to a court, and to others ordered by a  
19       court, if the protected health information is devel-  
20       oped in response to a court-ordered physical or men-  
21       tal examination; or

22           “(3) pursuant to a law requiring the reporting  
23       of specific medical information to law enforcement  
24       authorities.

1 **“SEC. 11842. LAW ENFORCEMENT.**

2       “(a) IN GENERAL.—A health care provider, health  
3 plan, health oversight agency, employer, or person who re-  
4 ceives protected health information under section 11823  
5 may disclose protected health information to a law en-  
6 forcement agency (other than a health oversight agency  
7 governed by section 11831) if the information is requested  
8 for use—

9               “(1) in an investigation or prosecution of a  
10 health information trustee;

11               “(2) in the identification of a victim or witness  
12 in a law enforcement inquiry; or

13               “(3) in connection with the investigation of  
14 criminal activity committed against the trustee or on  
15 premises controlled by the trustee.

16       “(b) CERTIFICATION.—When a law enforcement  
17 agency (other than a health oversight agency) requests  
18 that a health information trustee disclose protected health  
19 information under this section, the law enforcement agen-  
20 cy shall provide the trustee with a written certification  
21 that—

22               “(1) specifies the information requested;

23               “(2) states that the information is needed for a  
24 lawful purpose under this section; and

25               “(3) is signed by a supervisory official of a rank  
26 designated by the head of the agency.



1 “(c) RESTRICTIONS ON ADDITIONAL DISCLOSURE.—  
 2 Notwithstanding section 11811(e), protected health infor-  
 3 mation about an individual that is disclosed to a law en-  
 4 forcement agency under this section may be used in, or  
 5 disclosed for, an administrative, civil, or criminal action  
 6 or investigation against the individual if the action or in-  
 7 vestigation arises out of and is directly related to the ac-  
 8 tion or investigation for which the information was ob-  
 9 tained.

10 **“Subpart E—Disclosure Pursuant to Government**  
 11 **Subpoena or Warrant**

12 **“SEC. 11851. GOVERNMENT SUBPOENAS AND WARRANTS.**

13 “(a) IN GENERAL.—A health care provider, health  
 14 plan, health oversight agency, employer, or person who re-  
 15 ceives protected health information under section 11823  
 16 may disclose protected health information under this sec-  
 17 tion if the disclosure is pursuant to—

18 “(1) a subpoena issued under the authority of  
 19 a grand jury, and the trustee is provided a written  
 20 certification by the grand jury seeking the informa-  
 21 tion that the grand jury has complied with the appli-  
 22 cable access provisions of section 11852;

23 “(2) an administrative subpoena or a judicial  
 24 subpoena or warrant, and the trustee is provided a  
 25 written certification by the person seeking the infor-

1       mation that the person has complied with the appli-  
2       cable access provisions of section 11852; or

3           “(3) an administrative subpoena or a judicial  
4       subpoena or warrant, and the disclosure otherwise  
5       meets the conditions of section 11831, 11832,  
6       11841, or 11842.

7       “(b) RESTRICTIONS ON ADDITIONAL DISCLOSURE.—

8           “(1) ACTIONS OR INVESTIGATIONS.—Notwith-  
9       standing section 11811(c), protected health informa-  
10      tion about an individual that is received under sub-  
11      section (a) may be disclosed for, or used in, any ad-  
12      ministrative, civil, or criminal action or investigation  
13      against the individual if the action or investigation  
14      arises out of and is directly related to the inquiry for  
15      which the information was obtained.

16          “(2) SPECIAL RULE.—Protected health infor-  
17      mation about an individual that is received under  
18      subsection (a)(3) may not be disclosed by the recipi-  
19      ent unless the recipient complies with the conditions  
20      and restrictions on disclosure with which the recipi-  
21      ent would have been required to comply if the disclo-  
22      sure had been made under section 11831, 11832,  
23      11841, or 11842.

1 **“SEC. 11852. ACCESS PROCEDURES FOR LAW ENFORCE-**  
2 **MENT SUBPOENAS AND WARRANTS.**

3       “(a) PROBABLE CAUSE REQUIREMENT.—A govern-  
4 ment authority may not obtain protected health informa-  
5 tion about an individual under paragraph (1) or (2) of  
6 section 11851(a) for use in a law enforcement inquiry un-  
7 less there is probable cause to believe that the information  
8 is relevant to a legitimate law enforcement inquiry being  
9 conducted by the government authority.

10       “(b) WARRANTS.—A government authority that ob-  
11 tains protected health information about an individual  
12 under circumstances described in subsection (a) and pur-  
13 suant to a warrant shall, not later than 30 days after the  
14 date the warrant was executed, serve the individual with,  
15 or mail to the last known address of the individual, a no-  
16 tice that protected health information about the individual  
17 was so obtained, together with a notice of the individual’s  
18 right to challenge the warrant in accordance with section  
19 11853.

20       “(c) SUBPOENAS.—Except as provided in subsection  
21 (d), a government authority may not obtain protected  
22 health information about an individual under cir-  
23 cumstances described in subsection (a) and pursuant to  
24 a subpoena unless a copy of the subpoena has been served  
25 on the individual on or before the date of return of the  
26 subpoena, together with a notice of the individual’s right

1 to challenge the subpoena in accordance with section  
2 11853, and—

3 “(1) 30 days have passed since the date of serv-  
4 ice on the individual and within that time period the  
5 individual has not initiated a challenge in accordance  
6 with section 11853; or

7 “(2) disclosure is ordered by a court after chal-  
8 lenge under section 11853.

9 “(d) APPLICATION FOR DELAY.—

10 “(1) IN GENERAL.—A government authority  
11 may apply ex parte and under seal to an appropriate  
12 court to delay (for an initial period of not longer  
13 than 90 days) serving a notice or copy of a subpoena  
14 required under subsection (b) or (c) with respect to  
15 a law enforcement inquiry. The government author-  
16 ity may apply to the court for extensions of the  
17 delay.

18 “(2) REASONS FOR DELAY.—An application for  
19 a delay, or extension of a delay, under this sub-  
20 section shall state, with reasonable specificity, the  
21 reasons why the delay or extension is being sought.

22 “(3) EX PARTE ORDER.—The court shall enter  
23 an ex parte order delaying or extending the delay of  
24 notice, an order prohibiting the disclosure of the re-  
25 quest for, or disclosure of, the protected health in-

1       formation, and an order requiring the disclosure of  
2       the protected health information if the court finds  
3       that—

4               “(A) the inquiry being conducted is within  
5       the lawful jurisdiction of the government au-  
6       thority seeking the protected health informa-  
7       tion;

8               “(B) there is probable cause to believe that  
9       the protected health information being sought is  
10      relevant to a legitimate law enforcement in-  
11      quiry;

12              “(C) the government authority’s need for  
13      the information outweighs the privacy interest  
14      of the individual who is the subject of the infor-  
15      mation; and

16              “(D) there is reasonable ground to believe  
17      that receipt of notice by the individual will re-  
18      sult in—

19                      “(i) endangering the life or physical  
20                      safety of any individual;

21                      “(ii) flight from prosecution;

22                      “(iii) destruction of or tampering with  
23                      evidence or the information being sought;  
24                      or

1                   “(iv) intimidation of potential wit-  
2                   nesses.

3   **“SEC. 11853. CHALLENGE PROCEDURES FOR LAW EN-**  
4                   **FORCEMENT WARRANTS AND SUBPOENAS.**

5           “(a) MOTION TO QUASH.—Within 30 days after the  
6   date of service of a notice of execution or a copy of a sub-  
7   poena of a government authority seeking protected health  
8   information about an individual under paragraph (1) or  
9   (2) of section 11851(a), the individual may file a motion  
10   to quash—

11           “(1) in the case of a State judicial warrant or  
12   subpoena, in the court which issued the warrant or  
13   subpoena;

14           “(2) in the case of a warrant or subpoena is-  
15   sued under the authority of a State that is not a  
16   State judicial warrant or subpoena, in a court of  
17   competent jurisdiction; or

18           “(3) in the case of any other warrant or sub-  
19   poena issued under the authority of a Federal court  
20   or the United States, in the United States district  
21   court for the district in which the individual resides  
22   or in which the warrant or subpoena was issued.

23           “(b) COPY.—A copy of the motion shall be served by  
24   the individual upon the government authority by reg-  
25   istered or certified mail.

1       “(c) PROCEEDINGS.—The government authority may  
2 file with the court such papers, including affidavits and  
3 other sworn documents, as sustain the validity of the war-  
4 rant or subpoena. The individual may file with the court  
5 reply papers in response to the government authority’s fil-  
6 ing. The court, upon the request of the individual or the  
7 government authority or both, may proceed in camera.  
8 The court may conduct such proceedings as it deems ap-  
9 propriate to rule on the motion, but shall endeavor to ex-  
10 pedite its determination.

11       “(d) STANDARD FOR DECISION.—A court may deny  
12 a motion under subsection (a) if it finds there is probable  
13 cause to believe the protected health information is rel-  
14 evant to a legitimate law enforcement inquiry being con-  
15 ducted by the government authority, unless the court finds  
16 the individual’s privacy interest outweighs the government  
17 authority’s need for the information. The individual shall  
18 have the burden of demonstrating that the individual’s pri-  
19 vacy interest outweighs the need by the government au-  
20 thority for the information.

21       “(e) SPECIFIC CONSIDERATIONS WITH RESPECT TO  
22 PRIVACY INTEREST.—In reaching its determination, the  
23 court shall consider—

24               “(1) the particular purpose for which the infor-  
25 mation was collected;

1           “(2) the degree to which disclosure of the infor-  
2           mation will embarrass, injure, or invade the privacy  
3           of the individual;

4           “(3) the effect of the disclosure on the individ-  
5           ual’s future health care;

6           “(4) the importance of the inquiry being con-  
7           ducted by the government authority, and the impor-  
8           tance of the information to that inquiry; and

9           “(5) any other factor deemed relevant by the  
10          court.

11          “(f) ATTORNEY’S FEES.—In the case of a motion  
12          brought under subsection (a) in which the individual has  
13          substantially prevailed, the court may assess against the  
14          government authority a reasonable attorney’s fee and  
15          other litigation costs (including expert’s fees) reasonably  
16          incurred.

17          “(g) NO INTERLOCUTORY APPEAL.—A ruling deny-  
18          ing a motion to quash under this section shall not be  
19          deemed to be a final order, and no interlocutory appeal  
20          may be taken therefrom by the individual. An appeal of  
21          such a ruling may be taken by the individual within such  
22          period of time as is provided by law as part of any appeal  
23          from a final order in any legal proceeding initiated against  
24          the individual arising out of or based upon the protected  
25          health information disclosed.



1     **“Subpart F—Disclosure Pursuant to Private Party**  
2                                     **Subpoena**

3     **“SEC. 11854. PRIVATE PARTY SUBPOENAS.**

4             “A health care provider, health plan, employer, or  
5 person who receives protected health information under  
6 section 11823 may disclose protected health information  
7 under this section if the disclosure is pursuant to a sub-  
8 poena issued on behalf of a private party who has complied  
9 with the access provisions of section 11855.

10    **“SEC. 11855. ACCESS PROCEDURES FOR PRIVATE PARTY**  
11                                     **SUBPOENAS.**

12             “A private party may not obtain protected health in-  
13 formation about an individual pursuant to a subpoena un-  
14 less a copy of the subpoena together with a notice of the  
15 individual’s right to challenge the subpoena in accordance  
16 with section 11856 has been served upon the individual  
17 on or before the date of return of the subpoena, and—

18             “(1) 30 days have passed since the date of serv-  
19 ice on the individual, and within that time period the  
20 individual has not initiated a challenge in accordance  
21 with section 11856; or

22             “(2) disclosure is ordered by a court under sec-  
23 tion 11856.

1 **“SEC. 11856. CHALLENGE PROCEDURES FOR PRIVATE**  
2 **PARTY SUBPOENAS.**

3 “(a) MOTION TO QUASH SUBPOENA.—Within 30  
4 days after service of a copy of the subpoena seeking pro-  
5 tected health information under section 11854, the indi-  
6 vidual who is the subject of the protected health informa-  
7 tion may file in any court of competent jurisdiction a mo-  
8 tion to quash the subpoena and serve a copy of the motion  
9 on the person seeking the information.

10 “(b) STANDARD FOR DECISION.—The court shall  
11 grant a motion under subsection (a) unless the respondent  
12 demonstrates that—

13 “(1) there is reasonable ground to believe the  
14 information is relevant to a lawsuit or other judicial  
15 or administrative proceeding; and

16 “(2) the need of the respondent for the infor-  
17 mation outweighs the privacy interest of the individ-  
18 ual.

19 “(c) SPECIFIC CONSIDERATIONS WITH RESPECT TO  
20 PRIVACY INTEREST.—In determining under subsection  
21 (b) whether the need of the respondent for the information  
22 outweighs the privacy interest of the individual, the court  
23 shall consider—

24 “(1) the particular purpose for which the infor-  
25 mation was collected;

1           “(2) the degree to which disclosure of the infor-  
2           mation would embarrass, injure, or invade the pri-  
3           vacy of the individual;

4           “(3) the effect of the disclosure on the individ-  
5           ual’s future health care;

6           “(4) the importance of the information to the  
7           lawsuit or proceeding; and

8           “(5) any other relevant factor.

9           “(d) ATTORNEY’S FEES.—In the case of a motion  
10          brought under subsection (a) in which the individual has  
11          substantially prevailed, the court may assess against the  
12          respondent a reasonable attorney’s fee and other litigation  
13          costs and expenses (including expert’s fees) reasonably in-  
14          curred.

15       **“PART III—PROCEDURES FOR ENSURING SECU-**  
16       **RITY OF PROTECTED HEALTH INFORMATION**

17       **“Subpart A—Establishment of Safeguards**

18       **“SEC. 11861. ESTABLISHMENT OF SAFEGUARDS.**

19       “(a) IN GENERAL.—A health information trustee  
20       shall establish and maintain appropriate administrative,  
21       technical, and physical safeguards—

22           “(1) to ensure the integrity and confidentiality  
23           of protected health information created or received  
24           by the trustee; and

1           “(2) to protect against any anticipated threats  
2           or hazards to the security or integrity of such infor-  
3           mation.

4           “(b) REGULATIONS.—The Secretary shall promul-  
5           gate regulations regarding security measures for protected  
6           health information. In developing such regulations, the  
7           Secretary shall consult with appropriate private parties  
8           with expertise in safeguarding health information.

9           **“SEC. 11862. ACCOUNTING FOR DISCLOSURES.**

10          “(a) IN GENERAL.—

11               “(1) REQUIREMENT TO CREATE OR MAINTAIN  
12               RECORD.—A health information trustee shall create  
13               and maintain, with respect to any protected health  
14               information disclosed in exceptional circumstances  
15               (as described in paragraph (2)), a record of—

16                       “(A) the date and purpose of the disclo-  
17                       sure;

18                       “(B) the name of the person to whom or  
19                       to which the disclosure was made;

20                       “(C) the address of the person to whom or  
21                       to which the disclosure was made or the loca-  
22                       tion to which the disclosure was made; and

23                       “(D) the information disclosed, if the re-  
24                       cording of the information disclosed is prac-  
25                       ticable, taking into account the technical capa-

1           bilities of the system used to maintain the  
2           record and the costs of such maintenance.

3           “(2) EXCEPTIONAL CIRCUMSTANCES DE-  
4           SCRIBED.—For purposes of paragraph (1) protected  
5           health information is disclosed in exceptional cir-  
6           cumstances if the disclosure—

7                   “(A) is not a routine part of doing busi-  
8                   ness, as determined in accordance with guide-  
9                   lines promulgated by the Secretary; or

10                   “(B) is permitted under sections 11823  
11                   and 11832.

12           “(b) DISCLOSURE RECORD PART OF INFORMATION.—  
13           A record created and maintained under paragraph (a)  
14           shall be maintained as part of the protected health infor-  
15           mation to which the record pertains.

16           **“Subpart B—Review of Protected Health Information**  
17                   **By Subjects of the Information**

18           **“SEC. 11871. INSPECTION OF PROTECTED HEALTH INFOR-**  
19                   **MATION.**

20           “(a) IN GENERAL.—Except as provided in subsection  
21           (c), a health care provider or health plan—

22                   “(1) shall permit an individual who is the sub-  
23                   ject of protected health information to inspect any  
24                   such information that the provider or plan main-  
25                   tains;

1           “(2) shall permit the individual to have a copy  
2           of the information;

3           “(3) shall permit a person who has been des-  
4           ignated in writing by the individual who is the sub-  
5           ject of the information to inspect the information on  
6           behalf of the individual or to accompany the individ-  
7           ual during the inspection; and

8           “(4) may offer to explain or interpret informa-  
9           tion that is inspected or copied under this sub-  
10          section.

11          “(b) ADDITIONAL REQUESTS.—Except as provided in  
12          subsection (c), a health plan or health care provider shall,  
13          upon written request of an individual—

14               “(1) determine the identity of previous provid-  
15               ers to the individual; and

16               “(2) obtain protected health information re-  
17               garding the individual.

18          “(c) EXCEPTIONS.—A health care provider or health  
19          plan is not required by this section to permit inspection  
20          or copying of protected health information if any of the  
21          following conditions apply:

22               “(1) MENTAL HEALTH TREATMENT NOTES.—  
23               The information consists of psychiatric, psycho-  
24               logical, or mental health treatment notes, and the  
25               provider or plan determines, based on reasonable

1 medical judgment, that inspection or copying of the  
2 notes would cause sufficient harm to the individual  
3 who is the subject of the notes so as to outweigh the  
4 desirability of permitting access, and the provider or  
5 plan has not disclosed the notes to any person not  
6 directly engaged in treating the individual, except  
7 with the authorization of the individual or under  
8 compulsion of law.

9 “(2) INFORMATION ABOUT OTHERS.—The in-  
10 formation relates to an individual other than the in-  
11 dividual seeking to inspect or have a copy of the in-  
12 formation and the provider or plan determines,  
13 based on reasonable medical judgment, that inspec-  
14 tion or copying of the information would cause suffi-  
15 cient harm to 1 or both of the individuals so as to  
16 outweigh the desirability of permitting access.

17 “(3) ENDANGERMENT TO LIFE OR SAFETY.—  
18 The provider or plan determines that disclosure of  
19 the information could reasonably be expected to en-  
20 danger the life or physical safety of any individual.

21 “(4) CONFIDENTIAL SOURCE.—The information  
22 identifies or could reasonably lead to the identifica-  
23 tion of a person (other than a health care provider)  
24 who provided information under a promise of con-

1        confidentiality to a health care provider concerning the  
2        individual who is the subject of the information.

3            “(5) ADMINISTRATIVE PURPOSES.—The infor-  
4        mation—

5            “(A) is used by the provider or plan solely  
6        for administrative purposes and not in the pro-  
7        vision of health care to the individual who is the  
8        subject of the information; and

9            “(B) has not been disclosed by the pro-  
10       vider or plan to any other person.

11        “(d) INSPECTION AND COPYING OF SEGREGABLE  
12       PORTION.—A health care provider or health plan shall  
13       permit inspection and copying under subsection (a) of any  
14       reasonably segregable portion of a record after deletion of  
15       any portion that is exempt under subsection (c).

16        “(e) CONDITIONS.—A health care provider or health  
17       plan may require a written request for the inspection and  
18       copying of protected health information under this sub-  
19       section. The health care provider or health plan may re-  
20       quire a reasonable cost reimbursement for such inspection  
21       and copying.

22        “(f) STATEMENT OF REASONS FOR DENIAL.—If a  
23       health care provider or health plan denies a request for  
24       inspection or copying under this section, the provider or  
25       plan shall provide the individual who made the request (or



1 the individual's designated representative) with a written  
2 statement of the reasons for the denial.

3 “(g) DEADLINE.—A health care provider or health  
4 plan shall comply with or deny a request for inspection  
5 or copying of protected health information under this sec-  
6 tion within the 30-day period beginning on the date on  
7 which the provider or plan receives the request.

8 **“SEC. 11872. AMENDMENT OF PROTECTED HEALTH INFOR-**  
9 **MATION.**

10 “(a) IN GENERAL.—A health care provider or health  
11 plan shall, within the 45-day period beginning on the date  
12 on which the provider or plan receives from an individual  
13 a written request that the provider or plan correct or  
14 amend the information—

15 “(1) make the correction or amendment re-  
16 quested;

17 “(2) inform the individual of the correction or  
18 amendment that has been made; and

19 “(3) inform any person who is identified by the  
20 individual, who is not an officer, employee or agent  
21 of the provider or plan, and to whom the uncor-  
22 rected or unamended portion of the information was  
23 previously disclosed, of the correction or amendment  
24 that has been made.

1       “(b) REFUSAL TO CORRECT.—If the provider or plan  
2 refuses to make the corrections, the provider or plan shall  
3 inform the individual of—

4               “(1) the reasons for the refusal of the provider  
5 or plan to make the correction or amendment;

6               “(2) any procedures for further review of the  
7 refusal; and

8               “(3) the individual’s right to file with the pro-  
9 vider or plan a concise statement setting forth the  
10 requested correction or amendment and the individ-  
11 ual’s reasons for disagreeing with the refusal of the  
12 provider or plan.

13       “(c) BASES FOR REQUEST TO CORRECT OR AMEND.—  
14 An individual may request correction or amendment of  
15 protected health information about the individual under  
16 paragraph (a) if the information is not timely, accurate,  
17 relevant to the system of records, or complete.

18       “(d) STATEMENT OF DISAGREEMENT.—After an in-  
19 dividual has filed a statement of disagreement under para-  
20 graph (b)(3), the provider or plan, in any subsequent dis-  
21 closure of the disputed portion of the information—

22               “(1) shall include a copy of the individual’s  
23 statement; and

1           “(2) may include a concise statement of the  
2 reasons of the provider or plan for not making the  
3 requested correction or amendment.

4           “(e) RULE OF CONSTRUCTION.—This section shall  
5 not be construed to require a health care provider or  
6 health plan to conduct a formal, informal, or other hearing  
7 or proceeding concerning a request for a correction or  
8 amendment to protected health information the provider  
9 or plan maintains.

10          “(f) CORRECTION.—For purposes of paragraph (a),  
11 a correction is deemed to have been made to protected  
12 health information when information that is not timely,  
13 accurate, relevant to the system of records, or complete  
14 is clearly marked as incorrect or when supplementary cor-  
15 rect information is made part of the information.

16 **“SEC. 11873. NOTICE OF INFORMATION PRACTICES.**

17          “(a) PREPARATION OF WRITTEN NOTICE.—A health  
18 care provider or health plan shall prepare a written notice  
19 of information practices describing the following:

20           “(1) PERSONAL RIGHTS OF AN INDIVIDUAL.—  
21 The rights under this subpart of an individual who  
22 is the subject of protected health information, in-  
23 cluding the right to inspect and copy such informa-  
24 tion and the right to seek amendments to such infor-  
25 mation, and the procedures for authorizing disclo-

1       sures of protected health information and for revok-  
2       ing such authorizations.

3           “(2) PROCEDURES OF PROVIDER OR PLAN.—

4       The procedures established by the provider or plan  
5       for the exercise of the rights of individuals about  
6       whom protected health information is maintained.

7           “(3) AUTHORIZED DISCLOSURES.—The disclo-  
8       sures of protected health information that are au-  
9       thorized.

10       “(b) DISSEMINATION OF NOTICE.—A health care  
11      provider or health plan—

12           “(1) shall, upon request, provide any individual  
13       with a copy of the notice of information practices de-  
14       scribed in subsection (a); and

15           “(2) shall make reasonable efforts to inform in-  
16       dividuals in a clear and conspicuous manner of the  
17       existence and availability of the notice.

18       “(c) MODEL NOTICE.—The Secretary, after notice  
19      and opportunity for public comment, shall develop and dis-  
20      seminate a model notice of information practices for use  
21      by health care providers and health plans under this sec-  
22      tion.

1     **“Subpart C—Standards for Electronic Disclosures**

2     **“SEC. 11882. STANDARDS FOR ELECTRONIC DISCLOSURES.**

3         “The Secretary shall promulgate standards for dis-  
 4 closing protected health information in accordance with  
 5 this subtitle in electronic form. Such standards shall in-  
 6 clude standards relating to the creation, transmission, re-  
 7 ceipt, and maintenance, of any written document required  
 8 or authorized under this subtitle.

9                     **“PART IV—SANCTIONS**

10    **“Subpart A—No Sanctions for Permissible Actions**

11    **“SEC. 11891. NO LIABILITY FOR PERMISSIBLE DISCLO-**  
 12                     **SURES.**

13         “A health information trustee who makes a disclosure  
 14 of protected health information about an individual that  
 15 is permitted by this subtitle shall not be liable to the indi-  
 16 vidual for the disclosure under common law.

17    **“SEC. 11892. NO LIABILITY FOR INSTITUTIONAL REVIEW**  
 18                     **BOARD DETERMINATIONS.**

19         “If the members of an institutional review board  
 20 make a determination in good faith that—

21                 “(1) a health research project is of sufficient  
 22 importance to outweigh the intrusion into the pri-  
 23 vacy of an individual; and

24                 “(2) the effectiveness of the project requires use  
 25 of protected health information,

1 the members, the board, and the parent institution of the  
2 board shall not be liable to the individual as a result of  
3 the determination.

4 **“SEC. 11893. RELIANCE ON CERTIFIED ENTITY.**

5 “If a health information trustee contracts with a cer-  
6 tified health information network service to make a disclo-  
7 sure of any protected health information on behalf of such  
8 trustee in accordance with this subtitle and such service  
9 makes a disclosure of such information that is in violation  
10 of this subtitle, the trustee shall not be liable for to the  
11 individual who is the subject of the information for such  
12 unlawful disclosure.

13 **“Subpart B—Civil Sanctions**

14 **“SEC. 11901. CIVIL PENALTY.**

15 “(a) VIOLATION.—Any health information trustee  
16 who the Secretary determines has substantially failed to  
17 comply with this subtitle shall be subject, in addition to  
18 any other penalties that may be prescribed by law, to a  
19 civil penalty of not more than \$10,000 for each such viola-  
20 tion.

21 “(b) PROCEDURES FOR IMPOSITION OF PEN-  
22 ALTIES.—Section 1128A, other than subsections (a) and  
23 (b) and the second sentence of subsection (f) of that sec-  
24 tion, shall apply to the imposition of a civil monetary pen-  
25 alty under this section in the same manner as such provi-

1 sions apply with respect to the imposition of a penalty  
2 under section 1128A.

3 **“SEC. 11902. CIVIL ACTION.**

4 “(a) IN GENERAL.—An individual who is aggrieved  
5 by conduct in violation of this subtitle may bring a civil  
6 action to recover—

7 “(1) the greater of actual damages or liquidated  
8 damages of \$5,000;

9 “(2) punitive damages;

10 “(3) a reasonable attorney’s fee and expenses of  
11 litigation;

12 “(4) costs of litigation; and

13 “(5) such preliminary and equitable relief as  
14 the court determines to be appropriate.

15 “(b) LIMITATION.—No action may be commenced  
16 under this section more than 3 years after the date on  
17 which the violation was or should reasonably have been  
18 discovered.

19 **“Subpart C—Criminal Sanctions**

20 **“SEC. 11911. WRONGFUL DISCLOSURE OF PROTECTED**  
21 **HEALTH INFORMATION.**

22 “(a) OFFENSE.—A person who knowingly—

23 “(1) obtains protected health information relat-  
24 ing to an individual in violation of this subtitle; or

1           “(2) discloses protected health information to  
2           another person in violation of this subtitle,  
3 shall be punished as provided in subsection (b).

4           “(b) PENALTIES.—A person described in subsection  
5 (a) shall—

6           “(1) be fined not more than \$50,000, impris-  
7           oned not more than 1 year, or both;

8           “(2) if the offense is committed under false pre-  
9           tenses, be fined not more than \$100,000, imprisoned  
10          not more than 5 years, or both; and

11          “(3) if the offense is committed with intent to  
12          sell, transfer, or use protected health information for  
13          commercial advantage, personal gain, or malicious  
14          harm, fined not more than \$250,000, imprisoned not  
15          more than 10 years, or both.

16          **“PART V—ADMINISTRATIVE PROVISIONS**

17          **“SEC. 11921. RELATIONSHIP TO OTHER LAWS.**

18          “(a) STATE LAW.—Except as provided in subsections  
19 (b), (c), and (d), this subtitle preempts State law.

20          “(b) LAWS RELATING TO PUBLIC OR MENTAL  
21 HEALTH.—Nothing in this subtitle shall be construed to  
22 preempt or operate to the exclusion of any State law relat-  
23 ing to public health or mental health that prevents or reg-  
24 ulates disclosure of protected health information otherwise  
25 allowed under this subtitle.



1       “(c) PRIVILEGES.—Nothing in this subtitle is in-  
 2 tended to preempt or modify State common or statutory  
 3 law to the extent such law concerns a privilege of a witness  
 4 or person in a court of the State. This subtitle does not  
 5 supersede or modify Federal common or statutory law to  
 6 the extent such law concerns a privilege of a witness or  
 7 person in a court of the United States. Authorizations  
 8 pursuant to section 11812 shall not be construed as a  
 9 waiver of any such privilege.

10       “(d) CERTAIN DUTIES UNDER STATE OR FEDERAL  
 11 LAW.—This subtitle shall not be construed to preempt,  
 12 supersede, or modify the operation of—

13               “(1) any law that provides for the reporting of  
 14 vital statistics such as birth or death information;

15               “(2) any law requiring the reporting of abuse or  
 16 neglect information about any individual;

17               “(3) subpart II of part E of title XXVI of the  
 18 Public Health Service Act (relating to notifications  
 19 of emergency response employees of possible expo-  
 20 sure to infectious diseases); or

21               “(4) any Federal law or regulation governing  
 22 confidentiality of alcohol and drug patient records.

23 **“SEC. 11922. RIGHTS OF INCOMPETENTS.**

24       “(a) EFFECT OF DECLARATION OF INCOM-  
 25 PETENCE.—Except as provided in section 11923, if an in-

1 individual has been declared to be incompetent by a court  
2 of competent jurisdiction, the rights of the individual  
3 under this subtitle shall be exercised and discharged in  
4 the best interests of the individual through the individual's  
5 representative.

6 “(b) NO COURT DECLARATION.—Except as provided  
7 in section 11923, if a health care provider determines that  
8 an individual, who has not been declared to be incom-  
9 petent by a court of competent jurisdiction, suffers from  
10 a medical condition that prevents the individual from act-  
11 ing knowingly or effectively on the individual's own behalf,  
12 the right of the individual to authorize disclosure may be  
13 exercised and discharged in the best interest of the individ-  
14 ual by the individual's representative.

15 **“SEC. 11923. EXERCISE OF RIGHTS.**

16 “(a) INDIVIDUALS WHO ARE 18 OR LEGALLY CAPA-  
17 BLE.—In the case of an individual—

18 “(1) who is 18 years of age or older, all rights  
19 of the individual shall be exercised by the individual;  
20 or

21 “(2) who, acting alone, has the legal right, as  
22 determined by State law, to apply for and obtain a  
23 type of medical examination, care, or treatment and  
24 who has sought such examination, care, or treat-  
25 ment, the individual shall exercise all rights of an in-

1       dividual under this subtitle with respect to protected  
2       health information relating to such examination,  
3       care, or treatment.

4       “(b) INDIVIDUALS UNDER 18.—Except as provided  
5       in subsection (a)(2), in the case of an individual who is—

6               “(1) under 14 years of age, all the individual’s  
7       rights under this subtitle shall be exercised through  
8       the parent or legal guardian of the individual; or

9               “(2) 14, 15, 16, or 17 years of age, the rights  
10      of inspection and amendment, and the right to au-  
11      thorize disclosure of protected health information of  
12      the individual may be exercised either by the individ-  
13      ual or by the parent or legal guardian of the individ-  
14      ual.”.

15      (b) CONFORMING AMENDMENT.—Title XI of the So-  
16      cial Security Act (42 U.S.C. 1301 et seq.), as amended  
17      by section 601, is amended by striking the title and insert-  
18      ing the following:

1 **“TITLE XI—GENERAL PROVI-**  
 2 **SIONS, PEER REVIEW, ADMIN-**  
 3 **ISTRATIVE SIMPLIFICATION,**  
 4 **AND PRIVACY”.**

5 **TITLE VII—ENHANCED PEN-**  
 6 **ALTIES FOR HEALTH CARE**  
 7 **FRAUD**

8 **Subtitle A—All-Payer Fraud and**  
 9 **Abuse Control Program**

10 **SEC. 701. ALL-PAYER FRAUD AND ABUSE CONTROL PRO-**  
 11 **GRAM.**

12 (a) ESTABLISHMENT OF PROGRAM.—

13 (1) IN GENERAL.—Not later than January 1,  
 14 1995, the Secretary of Health and Human Services  
 15 (in this title referred to as the “Secretary”), acting  
 16 through the Office of the Inspector General of the  
 17 Department of Health and Human Services, and the  
 18 Attorney General shall establish a program—

19 (A) to coordinate Federal, State, and local  
 20 law enforcement programs to control fraud and  
 21 abuse with respect to the delivery of and pay-  
 22 ment for health care in the United States,

23 (B) to conduct investigations, audits, eval-  
 24 uations, and inspections relating to the delivery

1 of and payment for health care in the United  
2 States,

3 (C) to facilitate the enforcement of the  
4 provisions of sections 1128, 1128A, and 1128B  
5 of the Social Security Act and other statutes  
6 applicable to health care fraud and abuse, and

7 (D) to provide for the modification and es-  
8 tablishment of safe harbors and to issue inter-  
9 pretative rulings and special fraud alerts pursu-  
10 ant to section 703.

11 (2) COORDINATION WITH HEALTH CARE  
12 PLANS.—In carrying out the program established  
13 under paragraph (1), the Secretary and the Attorney  
14 General shall consult with, and arrange for the shar-  
15 ing of data with representatives of health care plans.

16 (3) REGULATIONS.—

17 (A) IN GENERAL.—The Secretary and the  
18 Attorney General shall by regulation establish  
19 standards to carry out the program under para-  
20 graph (1).

21 (B) INFORMATION STANDARDS.—

22 (i) IN GENERAL.—Such standards  
23 shall include standards relating to the fur-  
24 nishing of information by health care  
25 plans, providers, and others to enable the

1 Secretary and the Attorney General to  
2 carry out the program (including coordina-  
3 tion with health care plans under para-  
4 graph (2)).

5 (ii) CONFIDENTIALITY.—Such stand-  
6 ards shall include procedures to assure  
7 that such information is provided and uti-  
8 lized in a manner that appropriately pro-  
9 tects the confidentiality of the information  
10 and the privacy of individuals receiving  
11 health care services and items.

12 (iii) QUALIFIED IMMUNITY FOR PRO-  
13 VIDING INFORMATION.—The provisions of  
14 section 1157(a) of the Social Security Act  
15 (relating to limitation on liability) shall  
16 apply to a person providing information to  
17 the Secretary or the Attorney General in  
18 conjunction with their performance of du-  
19 ties under this section, in the same manner  
20 as such section applies to information pro-  
21 vided to organizations with a contract  
22 under part B of title XI of such Act, with  
23 respect to the performance of such a con-  
24 tract.

1 (C) DISCLOSURE OF OWNERSHIP INFOR-  
2 MATION.—

3 (i) IN GENERAL.—Such standards  
4 shall include standards relating to the dis-  
5 closure of ownership information described  
6 in clause (ii) by any entity providing health  
7 care services and items.

8 (ii) OWNERSHIP INFORMATION DE-  
9 SCRIBED.—The ownership information de-  
10 scribed in this clause includes—

11 (I) a description of such items  
12 and services provided by such entity;

13 (II) the names and unique physi-  
14 cian identification numbers of all phy-  
15 sicians with a financial relationship  
16 (as defined in section 1877(a)(2) of  
17 the Social Security Act) with such en-  
18 tity;

19 (III) the names of all other indi-  
20 viduals with such an ownership or in-  
21 vestment interest in such entity; and

22 (IV) any other ownership and re-  
23 lated information required to be dis-  
24 closed by such entity under section

1                   1124 or section 1124A of the Social  
2                   Security Act.

3                   (4) AUTHORIZATION OF APPROPRIATIONS FOR  
4                   INVESTIGATORS AND OTHER PERSONNEL.—In addi-  
5                   tion to any other amounts authorized to be appro-  
6                   priated to the Secretary and the Attorney General  
7                   for health care anti-fraud and abuse activities for a  
8                   fiscal year, there are authorized to be appropriated  
9                   additional amounts as may be necessary to enable  
10                  the Secretary and the Attorney General to conduct  
11                  investigations and audits of allegations of health  
12                  care fraud and abuse and otherwise carry out the  
13                  program established under paragraph (1) in a fiscal  
14                  year.

15                (5) ENSURING ACCESS TO DOCUMENTATION.—  
16                The Inspector General of the Department of Health  
17                and Human Services is authorized to exercise the  
18                authority described in paragraphs (4) and (5) of sec-  
19                tion 6 of the Inspector General Act of 1978 (relating  
20                to subpoenas and administration of oaths) with re-  
21                spect to the activities under the all-payer fraud and  
22                abuse control program established under this sub-  
23                section to the same extent as such Inspector General  
24                may exercise such authorities to perform the func-  
25                tions assigned by such Act.



1           (6) HEALTH CARE PLAN DEFINED.—For the  
2           purposes of this subsection, the term “health care  
3           plan” shall have the meaning given such term in sec-  
4           tion 1128(i) of the Social Security Act.

5           (b) ESTABLISHMENT OF ANTI-FRAUD AND ABUSE  
6           TRUST FUND.—

7           (1) ESTABLISHMENT.—

8           (A) IN GENERAL.—There is hereby created  
9           on the books of the Treasury of the United  
10          States a trust fund to be known as the “Anti-  
11          Fraud and Abuse Trust Fund” (in this section  
12          referred to as the “Trust Fund”). The Trust  
13          Fund shall consist of such gifts and bequests as  
14          may be made as provided in subparagraph (B)  
15          and such amounts as may be deposited in, or  
16          appropriated to, such Trust Fund as provided  
17          in subsection (a)(4), sections 731(b), 732(b),  
18          and 741(b) of this Act, and title XI of the So-  
19          cial Security Act.

20          (B) AUTHORIZATION TO ACCEPT GIFTS.—  
21          The Managing Trustee of the Trust Fund is  
22          authorized to accept on behalf of the United  
23          States money gifts and bequests made uncondi-  
24          tionally to the Trust Fund, for the benefit of

1 the Trust Fund, or any activity financed  
2 through the Trust Fund.

3 (2) MANAGEMENT.—

4 (A) IN GENERAL.—The Trust Fund shall  
5 be managed by the Secretary and the Attorney  
6 General through a Managing Trustee des-  
7 ignated by the Secretary and the Attorney Gen-  
8 eral.

9 (B) INVESTMENT OF FUNDS.—

10 (i) IN GENERAL.—It shall be the duty  
11 of the Managing Trustee to invest such  
12 portion of the Trust Fund as is not, in the  
13 Managing Trustee's judgment, required to  
14 meet current withdrawals.

15 (ii) GENERAL FORM OF INVEST-  
16 MENT.—Investments described in clause (i)  
17 may be made only in interest-bearing obli-  
18 gations of the United States or in obliga-  
19 tions guaranteed as to both principal and  
20 interest by the United States. For such  
21 purpose such obligations may be ac-  
22 quired—

23 (I) on original issue at the issue  
24 price, or

1 (II) by purchase of outstanding  
2 obligations at market price.

3 (iii) ISSUANCE OF PUBLIC-DEBT OBLI-  
4 GATIONS.—The purposes for which obliga-  
5 tions of the United States may be issued  
6 under chapter 31 of title 31, United States  
7 Code, are hereby extended to authorize the  
8 issuance at par of public-debt obligations  
9 for purchase by the Trust Fund. Such obli-  
10 gations issued for purchase by the Trust  
11 Fund shall have maturities fixed with due  
12 regard for the needs of the Trust Fund  
13 and shall bear interest at a rate equal to  
14 the average market yield (computed by the  
15 Managing Trustee on the basis of market  
16 quotations as of the end of the calendar  
17 month next preceding the date of such  
18 issue) on all marketable interest-bearing  
19 obligations of the United States then form-  
20 ing a part of the public debt which are not  
21 due or callable until after the expiration of  
22 4 years from the end of such calendar  
23 month, except that where such average is  
24 not a multiple of  $\frac{1}{8}$  of 1 percent, the rate  
25 of interest on such obligations shall be the

1 multiple of  $\frac{1}{8}$  of 1 percent nearest such  
2 market yield.

3 (iv) PURCHASES OF OTHER OBLIGA-  
4 TIONS.—The Managing Trustee may pur-  
5 chase other interest-bearing obligations of  
6 the United States or obligations guaran-  
7 teed as to both principal and interest by  
8 the United States, on original issue or at  
9 the market price, only where the Managing  
10 Trustee determines that the purchase of  
11 such other obligations is in the public in-  
12 terest.

13 (C) SALE OF OBLIGATIONS.—Any obliga-  
14 tions acquired by the Trust Fund (except pub-  
15 lic-debt obligations issued exclusively to the  
16 Trust Fund) may be sold by the Managing  
17 Trustee at the market price, and such public-  
18 debt obligations may be redeemed at par plus  
19 accrued interest.

20 (D) INTEREST ON OBLIGATIONS AND PRO-  
21 CEEDS FROM SALE OR REDEMPTION OF OBLI-  
22 GATIONS.—The interest on, and the proceeds  
23 from the sale or redemption of, any obligations  
24 held in the Trust Fund shall be credited to and  
25 form a part of the Trust Fund.

1           (E) RECEIPTS AND DISBURSEMENTS NOT  
2 INCLUDED IN UNITED STATES GOVERNMENT  
3 BUDGET TOTALS.—The receipts and disburse-  
4 ments of the Secretary and the Attorney Gen-  
5 eral in the discharge of the functions of the  
6 Secretary and the Attorney General under the  
7 all-payer fraud and abuse control program es-  
8 tablished under subsection (a) shall not be in-  
9 cluded in the totals of the budget of the United  
10 States Government. For purposes of part C of  
11 the Balanced Budget and Emergency Deficit  
12 Control Act of 1985, the Secretary, the Attor-  
13 ney General, and the Trust Fund shall be treat-  
14 ed in the same manner as the Federal Retire-  
15 ment Thrift Investment Board and the Thrift  
16 Savings Fund, respectively. The United States  
17 is not liable for any obligation or liability in-  
18 curred by the Trust Fund.

19           (3) USE OF FUNDS.—

20           (A) IN GENERAL.—Amounts in the Trust  
21 Fund shall be used without regard to fiscal year  
22 limitation to assist the Inspector General of the  
23 Department of Health and Human Services and  
24 the Attorney General in carrying out the all-

1 payer fraud and abuse control program estab-  
2 lished under subsection (a).

3 (B) OVERALL ADMINISTRATION.—The  
4 Managing Trustee shall also pay from time to  
5 time from the Trust Fund such amounts as the  
6 Secretary and the Attorney General certify are  
7 necessary to carry out the all-payer fraud and  
8 abuse control program established under sub-  
9 section (a).

10 (4) ANNUAL REPORT.—The Managing Trustee  
11 shall be required to submit an annual report to Con-  
12 gress on the amount of revenue which is generated  
13 and disbursed by the Trust Fund in each fiscal year.  
14 Such report shall include an estimate of the amount  
15 of additional appropriations authorized under sub-  
16 section (a)(4) necessary for the Secretary and the  
17 Attorney General to conduct the all-payer fraud and  
18 abuse program established under subsection (a) in  
19 the next fiscal year.

20 **SEC. 702. APPLICATION OF FEDERAL HEALTH ANTI-FRAUD**  
21 **AND ABUSE SANCTIONS TO ALL FRAUD AND**  
22 **ABUSE AGAINST ANY HEALTH CARE PLAN.**

23 (a) CIVIL MONETARY PENALTIES.—Section 1128A  
24 of the Social Security Act (42 U.S.C. 1320a–7a) is amend-  
25 ed as follows:

1           (1) In subsection (a)(1), by inserting “or of any  
2 health care plan (as defined in section 1128(i)),”  
3 after “subsection (i)(1)),”.

4           (2) In subsection (b)(1)(A), by inserting “or  
5 under a health care plan” after “title XIX”.

6           (3) In subsection (f)—

7                 (A) by redesignating paragraph (3) as  
8 paragraph (4); and

9                 (B) by inserting after paragraph (2) the  
10 following new paragraphs:

11                 “(3) With respect to amounts recovered arising  
12 out of a claim under a health care plan, the portion  
13 of such amounts as is determined to have been paid  
14 by the plan shall be repaid to the plan, and the por-  
15 tion of such amounts attributable to the amounts re-  
16 covered under this section by reason of the amend-  
17 ments made by title VII of the America’s Health  
18 Care Option Act (as estimated by the Secretary)  
19 shall be deposited into the Anti-Fraud and Abuse  
20 Trust Fund established under section 701(b) of such  
21 Act.”.

22           (4) In subsection (i)—

23                 (A) in paragraph (2), by inserting “or  
24 under a health care plan” before the period at  
25 the end, and

1 (B) in paragraph (5), by inserting “or  
2 under a health care plan” after “or XX”.

3 (b) CRIMES.—

4 (1) SOCIAL SECURITY ACT.—Section 1128B of  
5 such Act (42 U.S.C. 1320a–7b) is amended as fol-  
6 lows:

7 (A) In the heading, by adding at the end  
8 the following: “OR HEALTH CARE PLANS”.

9 (B) In subsection (a)(1)—

10 (i) by striking “title XVIII or” and  
11 inserting “title XVIII,” and

12 (ii) by adding at the end the follow-  
13 ing: “or a health care plan (as defined in  
14 section 1128(i)),”.

15 (C) In subsection (a)(5), by striking “title  
16 XVIII or a State health care program” and in-  
17 serting “title XVIII, a State health care pro-  
18 gram, or a health care plan”.

19 (D) In the second sentence of subsection  
20 (a)—

21 (i) by inserting after “title XIX” the  
22 following: “or a health care plan”, and

23 (ii) by inserting after “the State” the  
24 following: “or the plan”.



1           (E) In subsection (b)(1), by striking “title  
2           XVIII or a State health care program” each  
3           place it appears and inserting “title XVIII, a  
4           State health care program, or a health care  
5           plan”.

6           (F) In subsection (b)(2), by striking “title  
7           XVIII or a State health care program” each  
8           place it appears and inserting “title XVIII, a  
9           State health care program, or a health care  
10          plan”.

11          (G) In subsection (b)(3), by striking “title  
12          XVIII or a State health care program” each  
13          place it appears in subparagraphs (A) and (C)  
14          and inserting “title XVIII, a State health care  
15          program, or a health care plan”.

16          (H) In subsection (d)(2)—

17               (i) by striking “title XIX,” and insert-  
18               ing “title XIX or under a health care  
19               plan,” and

20               (ii) by striking “State plan,” and in-  
21               serting “State plan or the health care  
22               plan,”.

23          (2) IDENTIFICATION OF COMMUNITY SERVICE  
24          OPPORTUNITIES.—Section 1128B of such Act (42

1 U.S.C. 1320a–7b) is further amended by adding at  
2 the end the following new subsection:

3 “(f) The Secretary may—

4 “(1) in consultation with State and local health  
5 care officials, identify opportunities for the satisfac-  
6 tion of community service obligations that a court  
7 may impose upon the conviction of an offense under  
8 this section, and

9 “(2) make information concerning such oppor-  
10 tunities available to Federal and State law enforce-  
11 ment officers and State and local health care  
12 officials.”.

13 (c) HEALTH CARE PLAN DEFINED.—Section 1128 of  
14 such Act (42 U.S.C. 1320a–7) is amended by redesignat-  
15 ing subsection (i) as subsection (j) and by inserting after  
16 subsection (h) the following new subsection:

17 “(i) HEALTH CARE PLAN DEFINED.—For purposes  
18 of sections 1128A and 1128B, the term ‘health care plan’  
19 means a public or private program for the delivery of or  
20 payment for health care items or services other than the  
21 medicare program, the medicaid program, or a State  
22 health care program.”.

23 (d) EFFECTIVE DATE.—The amendments made by  
24 this section shall take effect on January 1, 1995.

1 **SEC. 703. HEALTH CARE FRAUD AND ABUSE GUIDANCE.**

2 (a) SOLICITATION AND PUBLICATION OF MODIFICA-  
3 TIONS TO EXISTING SAFE HARBORS AND NEW SAFE  
4 HARBORS.—

5 (1) IN GENERAL.—

6 (A) SOLICITATION OF PROPOSALS FOR  
7 SAFE HARBORS.—Not later than January 1,  
8 1995, and not less than annually thereafter, the  
9 Secretary shall publish a notice in the Federal  
10 Register soliciting proposals, which will be ac-  
11 cepted during a 60-day period, for—

12 (i) modifications to existing safe har-  
13 bors issued pursuant to section 14(a) of  
14 the Medicare and Medicaid Patient and  
15 Program Protection Act of 1987 (42  
16 U.S.C. 1320a–7b note);

17 (ii) additional safe harbors specifying  
18 payment practices that shall not be treated  
19 as a criminal offense under section  
20 1128B(b) of the Social Security Act the  
21 (42 U.S.C. 1320a–7b(b)) and shall not  
22 serve as the basis for an exclusion under  
23 section 1128(b)(7) of such Act (42 U.S.C.  
24 1320a–7(b)(7));

25 (iii) interpretive rulings to be issued  
26 pursuant to subsection (b); and

1 (iv) special fraud alerts to be issued  
2 pursuant to subsection (c).

3 (B) PUBLICATION OF PROPOSED MODI-  
4 FICATIONS AND PROPOSED ADDITIONAL STATE  
5 HARBORS.—After considering the proposals de-  
6 scribed in clauses (i) and (ii) of subparagraph  
7 (A), the Secretary, in consultation with the At-  
8 torney General, shall publish in the Federal  
9 Register proposed modifications to existing safe  
10 harbors and proposed additional safe harbors, if  
11 appropriate, with a 60-day comment period.  
12 After considering any public comments received  
13 during this period, the Secretary shall issue  
14 final rules modifying the existing safe harbors  
15 and establishing new safe harbors, as appro-  
16 priate.

17 (C) REPORT.—The Inspector General of  
18 the Department of Health and Human Services  
19 (hereafter in this section referred to as the “In-  
20 spector General”) shall, in an annual report to  
21 Congress or as part of the year-end semiannual  
22 report required by section 5 of the Inspector  
23 General Act of 1978 (5 U.S.C. App.), describe  
24 the proposals received under clauses (i) and (ii)  
25 of subparagraph (A) and explain which propos-

1           als were included in the publication described in  
2           subparagraph (B), which proposals were not in-  
3           cluded in that publication, and the reasons for  
4           the rejection of the proposals that were not in-  
5           cluded.

6           (2) CRITERIA FOR MODIFYING AND ESTABLISH-  
7           ING SAFE HARBORS.—In modifying and establishing  
8           safe harbors under paragraph (1)(B), the Secretary  
9           may consider the extent to which providing a safe  
10          harbor for the specified payment practice may result  
11          in any of the following:

12                 (A) An increase or decrease in access to  
13                 health care services.

14                 (B) An increase or decrease in the quality  
15                 of health care services.

16                 (C) An increase or decrease in patient free-  
17                 dom of choice among health care providers.

18                 (D) An increase or decrease in competition  
19                 among health care providers.

20                 (E) An increase or decrease in the ability  
21                 of health care facilities to provide services in  
22                 medically underserved areas or to medically un-  
23                 derserved populations.

24                 (F) An increase or decrease in the cost to  
25                 Government health care programs.

1 (G) An increase or decrease in the poten-  
2 tial overutilization of health care services.

3 (H) The existence or nonexistence of any  
4 potential financial benefit to a health care pro-  
5 fessional or provider which may vary based on  
6 their decisions of—

7 (i) whether to order a health care  
8 item or service; or

9 (ii) whether to arrange for a referral  
10 of health care items or services to a par-  
11 ticular practitioner or provider.

12 (I) Any other factors the Secretary deems  
13 appropriate in the interest of preventing fraud  
14 and abuse in Government health care programs.

15 (b) INTERPRETIVE RULINGS.—

16 (1) IN GENERAL.—

17 (A) REQUEST FOR INTERPRETIVE RUL-  
18 ING.—Any person may present, at any time, a  
19 request to the Inspector General for a state-  
20 ment of the Inspector General’s current inter-  
21 pretation of the meaning of a specific aspect of  
22 the application of sections 1128A and 1128B of  
23 the Social Security Act (hereafter in this sec-  
24 tion referred to as an “interpretive ruling”).

1 (B) ISSUANCE AND EFFECT OF INTERPRE-  
2 TIVE RULING.—

3 (i) IN GENERAL.—If appropriate, the  
4 Inspector General shall in consultation  
5 with the Attorney General, issue an inter-  
6 pretive ruling in response to a request de-  
7 scribed in subparagraph (A). Interpretive  
8 rulings shall not have the force of law and  
9 shall be treated as an interpretive rule  
10 within the meaning of section 553(b) of  
11 title 5, United States Code. All interpretive  
12 rulings issued pursuant to this provision  
13 shall be published in the Federal Register  
14 or otherwise made available for public in-  
15 spection.

16 (ii) REASONS FOR DENIAL.—If the In-  
17 spector General does not issue an interpre-  
18 tive ruling in response to a request de-  
19 scribed in subparagraph (A), the Inspector  
20 General shall notify the requesting party of  
21 such decision and shall identify the reasons  
22 for such decision.

23 (2) CRITERIA FOR INTERPRETIVE RULINGS.—

1 (A) IN GENERAL.—In determining whether  
2 to issue an interpretive ruling under paragraph  
3 (1)(B), the Inspector General may consider—

4 (i) whether and to what extent the re-  
5 quest identifies an ambiguity within the  
6 language of the statute, the existing safe  
7 harbors, or previous interpretive rulings;  
8 and

9 (ii) whether the subject of the re-  
10 quested interpretive ruling can be ade-  
11 quately addressed by interpretation of the  
12 language of the statute, the existing safe  
13 harbor rules, or previous interpretive rul-  
14 ings, or whether the request would require  
15 a substantive ruling not authorized under  
16 this subsection.

17 (B) NO RULINGS ON FACTUAL ISSUES.—

18 The Inspector General shall not give an inter-  
19 pretive ruling on any factual issue, including  
20 the intent of the parties or the fair market  
21 value of particular leased space or equipment.

22 (c) SPECIAL FRAUD ALERTS.—

23 (1) IN GENERAL.—

24 (A) REQUEST FOR SPECIAL FRAUD  
25 ALERTS.—Any person may present, at any



1 time, a request to the Inspector General for a  
2 notice which informs the public of practices  
3 which the Inspector General considers to be  
4 suspect or of particular concern under section  
5 1128B(b) of the Social Security Act (42 U.S.C.  
6 1320a-7b(b)) (hereafter in this subsection re-  
7 ferred to as a “special fraud alert”).

8 (B) ISSUANCE AND PUBLICATION OF SPE-  
9 CIAL FRAUD ALERTS.—Upon receipt of a re-  
10 quest described in subparagraph (A), the In-  
11 spector General shall investigate the subject  
12 matter of the request to determine whether a  
13 special fraud alert should be issued. If appro-  
14 priate, the Inspector General shall in consulta-  
15 tion with the Attorney General, issue a special  
16 fraud alert in response to the request. All spe-  
17 cial fraud alerts issued pursuant to this sub-  
18 paragraph shall be published in the Federal  
19 Register.

20 (2) CRITERIA FOR SPECIAL FRAUD ALERTS.—  
21 In determining whether to issue a special fraud alert  
22 upon a request described in paragraph (1), the In-  
23 spector General may consider—

24 (A) whether and to what extent the prac-  
25 tices that would be identified in the special

1 fraud alert may result in any of the con-  
 2 sequences described in subsection (a)(2); and

3 (B) the volume and frequency of the con-  
 4 duct that would be identified in the special  
 5 fraud alert.

6 **SEC. 704. REPORTING OF FRAUDULENT ACTIONS UNDER**  
 7 **MEDICARE.**

8 Not later than 1 year after the date of the enactment  
 9 of this Act, the Secretary shall establish a program  
 10 through which individuals entitled to benefits under the  
 11 medicare program may report to the Secretary on a con-  
 12 fidential basis (at the individual's request) instances of  
 13 suspected fraudulent actions arising under the program by  
 14 providers of items and services under the program.

15 **Subtitle B—Revisions to Current**  
 16 **Sanctions for Fraud and Abuse**

17 **SEC. 711. MANDATORY EXCLUSION FROM PARTICIPATION**  
 18 **IN MEDICARE AND STATE HEALTH CARE PRO-**  
 19 **GRAMS.**

20 (a) INDIVIDUAL CONVICTED OF FELONY RELATING  
 21 TO FRAUD.—

22 (1) IN GENERAL.—Section 1128(a) of the  
 23 Social Security Act (42 U.S.C. 1320a–7(a)) is  
 24 amended by adding at the end the following new  
 25 paragraph:

1           “(3) FELONY CONVICTION RELATING TO  
 2 FRAUD.—Any individual or entity that has been con-  
 3 victed, under Federal or State law, in connection  
 4 with the delivery of a health care item or service or  
 5 with respect to any act or omission in a program  
 6 (other than those specifically described in paragraph  
 7 (1)) operated by or financed in whole or in part by  
 8 any Federal, State, or local government agency, of  
 9 a criminal offense consisting of a felony relating to  
 10 fraud, theft, embezzlement, breach of fiduciary re-  
 11 sponsibility, or other financial misconduct.”.

12           (2) CONFORMING AMENDMENT.—Section  
 13 1128(b)(1) of such Act (42 U.S.C. 1320a–7(b)(1))  
 14 is amended—

15           (A) in the heading, by striking “CONVIC-  
 16 TION” and inserting “MISDEMEANOR CONVIC-  
 17 TION”; and

18           (B) by striking “criminal offense” and in-  
 19 serting “criminal offense consisting of a mis-  
 20 demeanor”.

21           (b) INDIVIDUAL CONVICTED OF FELONY RELATING  
 22 TO CONTROLLED SUBSTANCE.—

23           (1) IN GENERAL.—Section 1128(a) of the So-  
 24 cial Security Act (42 U.S.C. 1320a–7(a)), as amend-

1 ed by subsection (a), is amended by adding at the  
 2 end the following new paragraph:

3 “(4) FELONY CONVICTION RELATING TO CON-  
 4 TROLLED SUBSTANCE.—Any individual or entity  
 5 that has been convicted, under Federal or State law,  
 6 of a criminal offense consisting of a felony relating  
 7 to the unlawful manufacture, distribution, prescrip-  
 8 tion, or dispensing of a controlled substance.”.

9 (2) CONFORMING AMENDMENT.—Section  
 10 1128(b)(3) of such Act (42 U.S.C. 1320a–7(b)(3))  
 11 is amended—

12 (A) in the heading, by striking “CONVIC-  
 13 TION” and inserting “MISDEMEANOR CONVIC-  
 14 TION”; and

15 (B) by striking “criminal offense” and in-  
 16 serting “criminal offense consisting of a mis-  
 17 demeanor”.

18 **SEC. 712. ESTABLISHMENT OF MINIMUM PERIOD OF EX-**  
 19 **CLUSION FOR CERTAIN INDIVIDUALS AND**  
 20 **ENTITIES SUBJECT TO PERMISSIVE EXCLU-**  
 21 **SION FROM MEDICARE AND STATE HEALTH**  
 22 **CARE PROGRAMS.**

23 Section 1128(c)(3) of the Social Security Act (42  
 24 U.S.C. 1320a–7(c)(3)) is amended by adding at the end  
 25 the following new subparagraphs:

1       “(D) In the case of an exclusion of an individual or  
 2 entity under paragraph (1), (2), or (3) of subsection (b),  
 3 the period of the exclusion shall be 3 years, unless the  
 4 Secretary determines in accordance with published regula-  
 5 tions that a shorter period is appropriate because of miti-  
 6 gating circumstances or that a longer period is appro-  
 7 priate because of aggravating circumstances.

8       “(E) In the case of an exclusion of an individual or  
 9 entity under subsection (b)(4) or (b)(5), the period of the  
 10 exclusion shall not be less than the period during which  
 11 the individual’s or entity’s license to provide health care  
 12 is revoked, suspended, or surrendered, or the individual  
 13 or the entity is excluded or suspended from a Federal or  
 14 State health care program.

15       “(F) In the case of an exclusion of an individual or  
 16 entity under subsection (b)(6)(B), the period of the exclu-  
 17 sion shall be not less than 1 year.”.

18 **SEC. 713. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH**  
 19 **OWNERSHIP OR CONTROL INTEREST IN**  
 20 **SANCTIONED ENTITIES.**

21       Section 1128(b) of the Social Security Act (42 U.S.C.  
 22 1320a–7(b)) is amended by adding at the end the follow-  
 23 ing new paragraph:

24               “(15) INDIVIDUALS CONTROLLING A SANC-  
 25 TIONED ENTITY.—Any individual who has a direct

1 or indirect ownership or control interest of 5 percent  
 2 or more, or an ownership or control interest (as de-  
 3 fined in section 1124(a)(3)) in, or who is an officer,  
 4 director, agent, or managing employee (as defined in  
 5 section 1126(b)) of, an entity—

6 “(A) that has been convicted of any of-  
 7 fense described in subsection (a) or in para-  
 8 graph (1), (2), or (3) of this subsection;

9 “(B) against which a civil monetary pen-  
 10 alty has been assessed under section 1128A; or

11 “(C) that has been excluded from partici-  
 12 pation under a program under title XVIII or  
 13 under a State health care program.”.

14 **SEC. 714. CIVIL MONETARY PENALTIES.**

15 (a) PROHIBITION AGAINST OFFERING INDUCEMENTS  
 16 TO INDIVIDUALS ENROLLED UNDER OR EMPLOYED BY  
 17 PROGRAMS OR PLANS.—

18 (1) INDUCEMENTS TO INDIVIDUALS ENROLLED  
 19 UNDER MEDICARE.—

20 (A) OFFER OF REMUNERATION.—Section  
 21 1128A(a) of the Social Security Act (42 U.S.C.  
 22 1320a–7a(a)) is amended—

23 (i) by striking “or” at the end of  
 24 paragraph (1)(D);

1 (ii) by striking “, or” at the end of  
2 paragraph (2) and inserting a semicolon;

3 (iii) by striking the semicolon at the  
4 end of paragraph (3) and inserting “; or”;  
5 and

6 (iv) by inserting after paragraph (3)  
7 the following new paragraph:

8 “(4) offers to or transfers remuneration to any  
9 individual eligible for benefits under title XVIII of  
10 this Act, or under a State health care program (as  
11 defined in section 1128(h)) that such person knows  
12 or should know is likely to influence such individual  
13 to order or receive from a particular provider, practi-  
14 tioner, or supplier any item or service for which pay-  
15 ment may be made, in whole or in part, under title  
16 XVIII, or a State health care program;”.

17 (B) REMUNERATION DEFINED.—Section  
18 1128A(i) is amended by adding the following  
19 new paragraph:

20 “(6) The term ‘remuneration’ includes the waiv-  
21 er of coinsurance and deductible amounts (or any  
22 part thereof), and transfers of items or services for  
23 free or for other than fair market value. The term  
24 ‘remuneration’ does not include the waiver of coin-  
25 surance and deductible amounts by a person, if—

1           “(A) the waiver is not offered as part of  
2           any advertisement or solicitation;

3           “(B) the person does not routinely waive  
4           coinsurance or deductible amounts; and

5           “(C) the person—

6                 “(i) waives the coinsurance and de-  
7                 ductible amounts after determining in good  
8                 faith that the individual is in financial  
9                 need;

10               “(ii) fails to collect coinsurance or de-  
11               ductible amounts after making reasonable  
12               collection efforts; or

13               “(iii) provides for any permissible  
14               waiver as specified in section 1128B(b)(3)  
15               or in regulations issued by the Secretary.”.

16           (2) INDUCEMENTS TO EMPLOYEES.—Section  
17           1128A(a) of such Act (42 U.S.C. 1320a–7a(a)), as  
18           amended by paragraph (1), is further amended—

19               (A) by striking “or” at the end of para-  
20               graph (3);

21               (B) by striking the semicolon at the end of  
22               paragraph (4) and inserting “; or”; and

23               (C) by inserting after paragraph (4) the  
24               following new paragraph:



1           “(5) pays a bonus, reward, or any other remuneration, directly or indirectly, to an employee to induce the employee to encourage individuals to seek or obtain covered items or services for which payment may be made under the medicare program, or a State health care program where the amount of the remuneration is determined in a manner that takes into account (directly or indirectly) the value or volume of any referrals by the employee to the employer for covered items or services;”.

11       (b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP OR CONTROL INTEREST IN PARTICIPATING ENTITY.—  
12 OR CONTROL INTEREST IN PARTICIPATING ENTITY.—  
13 Section 1128A(a) of such Act, as amended by subsection  
14 (a), is further amended—

15           (1) by striking “or” at the end of paragraph  
16 (4);

17           (2) by striking the semicolon at the end of  
18 paragraph (5) and inserting “; or”; and

19           (3) by inserting after paragraph (5) the following new paragraph:

21           “(6) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the

1 time of a violation of this subsection, retains a direct  
2 or indirect ownership or control interest of 5 percent  
3 or more, or an ownership or control interest (as de-  
4 fined in section 1124(a)(3)) in, or who is an officer,  
5 director, agent, or managing employee (as defined in  
6 section 1126(b)) of, an entity that is participating in  
7 a program under title XVIII or a State health care  
8 program;”.

9 (c) MISUSE OF HEALTH SECURITY CARD OR UNIQUE  
10 HEALTH IDENTIFIER.—Section 1128A(a) of such Act, as  
11 amended by subsection (b), is further amended—

12 (1) by striking “or” at the end of paragraph  
13 (5);

14 (2) by striking the semicolon at the end of  
15 paragraph (6) and inserting “; or”; and

16 (3) by inserting after paragraph (6) the follow-  
17 ing new paragraphs:

18 “(7) requires the display of, requires the use of,  
19 or uses a health security card that is issued under  
20 subtitle B of this title for any purpose other than a  
21 purpose described in such subtitle;

22 “(8) requires the disclosure of, requires the use  
23 of, or uses an individual’s unique health identifier  
24 established under subtitle B of this title for any pur-  
25 pose that is not authorized by the Secretary;”.

1 (d) MODIFICATIONS OF AMOUNTS OF PENALTIES  
2 AND ASSESSMENTS.—Section 1128A(a) of such Act (42  
3 U.S.C. 1320a–7a(a)), as amended by subsections (a) and  
4 (b), is amended in the matter following paragraph (6)—

5 (1) by striking “\$2,000” and inserting  
6 “\$10,000”;

7 (2) by inserting “; in cases under paragraph  
8 (4), \$10,000 for each such offer or transfer; in cases  
9 under paragraph (5), \$10,000 for each such pay-  
10 ment; in cases under paragraph (6), \$10,000 for  
11 each day the prohibited relationship occurs; in cases  
12 under paragraph (7) or (8), \$10,000 per violation”  
13 after “false or misleading information was given”;

14 (3) by striking “twice the amount” and insert-  
15 ing “3 times the amount”; and

16 (4) by inserting “(or, in cases under paragraphs  
17 (4) and (5), 3 times the amount of the illegal remu-  
18 neration)” after “for each such item or service”.

19 (e) CLAIM FOR ITEM OR SERVICE BASED ON INCOR-  
20 RECT CODING OR MEDICALLY UNNECESSARY SERV-  
21 ICES.—Section 1128A(a)(1) of such Act (42 U.S.C.  
22 1320a–7a(a)(1)) is amended—

23 (1) in subparagraph (A) by striking “claimed,”  
24 and inserting the following: “claimed, including any  
25 person who presents or causes to be presented a

1 claim for an item or service that is based on a code  
 2 that the person knows or should know will result in  
 3 a greater payment to the person than the code the  
 4 person knows or should know is applicable to the  
 5 item or service actually provided,”;

6 (2) in subparagraph (C), by striking “or” at  
 7 the end;

8 (3) in subparagraph (D), by striking “; or” and  
 9 inserting “, or”; and

10 (4) by inserting after subparagraph (D) the fol-  
 11 lowing new subparagraph:

12 “(E) is for a medical or other item or serv-  
 13 ice that a person knows or should know is not  
 14 medically necessary; or”.

15 **SEC. 715. ACTIONS SUBJECT TO CRIMINAL PENALTIES.**

16 (a) PERMITTING SECRETARY TO IMPOSE CIVIL MON-  
 17 ETARY PENALTY.—Section 1128A(b) of the Social Secu-  
 18 rity Act (42 U.S.C. 1320a–7a(a)) is amended by adding  
 19 the following new paragraph:

20 “(3) Any person (including any organization,  
 21 agency, or other entity, but excluding a beneficiary  
 22 as defined in subsection (i)(5)) who the Secretary  
 23 determines has violated section 1128B(b) of this  
 24 title shall be subject to a civil monetary penalty of  
 25 not more than \$10,000 for each such violation. In

1 addition, such person shall be subject to an assess-  
2 ment of not more than twice the total amount of the  
3 remuneration offered, paid, solicited, or received in  
4 violation of section 1128B(b). The total amount of  
5 remuneration subject to an assessment shall be cal-  
6 culated without regard to whether some portion  
7 thereof also may have been intended to serve a pur-  
8 pose other than one proscribed by section  
9 1128B(b).”.

10 (b) RESTRICTION ON APPLICATION OF EXCEPTION  
11 FOR AMOUNTS PAID TO EMPLOYEES.—Section  
12 1128B(b)(3)(B) of such Act (42 U.S.C. 1320a-  
13 7b(b)(3)(B)) is amended by striking “services;” and in-  
14 serting the following: “services, but only if the amount of  
15 remuneration under the arrangement is (i) consistent with  
16 fair market value; (ii) not determined in a manner that  
17 takes into account (directly or indirectly) the volume or  
18 value of any referrals by the employee to the employer for  
19 the furnishing (or arranging for the furnishing) of such  
20 items or services; and (iii) provided pursuant to an ar-  
21 rangement that would be commercially reasonable even if  
22 no referrals were made;”.

1 **SEC. 716. SANCTIONS AGAINST PRACTITIONERS AND PER-**  
2 **SONS FOR FAILURE TO COMPLY WITH STATU-**  
3 **TORY OBLIGATIONS.**

4 (a) MINIMUM PERIOD OF EXCLUSION FOR PRACTI-  
5 TIONERS AND PERSONS FAILING TO MEET STATUTORY  
6 OBLIGATIONS.—

7 (1) IN GENERAL.—The second sentence of sec-  
8 tion 1156(b)(1) of the Social Security Act (42  
9 U.S.C. 1320c-5(b)(1)) is amended by striking “may  
10 prescribe)” and inserting “may prescribe, except  
11 that such period may not be less than 1 year)”.

12 (2) CONFORMING AMENDMENT.—Section  
13 1156(b)(2) of such Act (42 U.S.C. 1320c-5(b)(2)) is  
14 amended by striking “shall remain” and inserting  
15 “shall (subject to the minimum period specified in  
16 the second sentence of paragraph (1)) remain”.

17 (b) REPEAL OF “UNWILLING OR UNABLE” CONDI-  
18 TION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1)  
19 of such Act (42 U.S.C. 1320c-5(b)(1)) is amended—

20 (1) in the second sentence, by striking “and de-  
21 termines” and all that follows through “such obliga-  
22 tions,”; and

23 (2) by striking the third sentence.

24 (c) AMOUNT OF CIVIL MONEY PENALTY.—Section  
25 1156(b)(3) of such Act (42 U.S.C. 1320c-5(b)(3)) is

1 amended by striking “the actual or estimated cost” and  
2 inserting the following: “up to \$10,000 for each instance”.

3 **SEC. 717. INTERMEDIATE SANCTIONS FOR MEDICARE**  
4 **HEALTH MAINTENANCE ORGANIZATIONS.**

5 (a) APPLICATION OF INTERMEDIATE SANCTIONS FOR  
6 ANY PROGRAM VIOLATIONS.—

7 (1) IN GENERAL.—Section 1876(i)(1) of the  
8 Social Security Act (42 U.S.C. 1395mm(i)(1)) is  
9 amended by striking “the Secretary may terminate”  
10 and all that follows and inserting the following: “in  
11 accordance with procedures established under para-  
12 graph (9), the Secretary may at any time terminate  
13 any such contract or may impose the intermediate  
14 sanctions described in paragraph (6)(B) or (6)(C)  
15 (whichever is applicable) on the eligible organization  
16 if the Secretary determines that the organization—

17 “(A) has failed substantially to carry out  
18 the contract;

19 “(B) is carrying out the contract in a man-  
20 ner inconsistent with the efficient and effective  
21 administration of this section;

22 “(C) is operating in a manner that is not  
23 in the best interests of the individuals covered  
24 under the contract; or

1           “(D) no longer substantially meets the ap-  
2           plicable conditions of subsections (b), (c), (e),  
3           and (f).”.

4           (2) OTHER INTERMEDIATE SANCTIONS FOR  
5           MISCELLANEOUS PROGRAM VIOLATIONS.—Section  
6           1876(i)(6) of such Act (42 U.S.C. 1395mm(i)(6)) is  
7           amended by adding at the end the following new  
8           subparagraph:

9           “(C) In the case of an eligible organization for which  
10          the Secretary makes a determination under paragraph (1)  
11          the basis of which is not described in subparagraph (A),  
12          the Secretary may apply the following intermediate sanc-  
13          tions:

14               “(i) Civil money penalties of not more than  
15               \$25,000 for each determination under paragraph (1)  
16               if the deficiency that is the basis of the determina-  
17               tion has directly adversely affected (or has the sub-  
18               stantial likelihood of adversely affecting) an individ-  
19               ual covered under the organization’s contract.

20               “(ii) Civil money penalties of not more than  
21               \$10,000 for each week beginning after the initiation  
22               of procedures by the Secretary under paragraph (9)  
23               during which the deficiency that is the basis of a de-  
24               termination under paragraph (1) exists.



1           “(iii) Suspension of enrollment of individuals  
2           under this section after the date the Secretary noti-  
3           fies the organization of a determination under para-  
4           graph (1) and until the Secretary is satisfied that  
5           the deficiency that is the basis for the determination  
6           has been corrected and is not likely to recur.”.

7           (3) PROCEDURES FOR IMPOSING SANCTIONS.—  
8           Section 1876(i) of such Act (42 U.S.C. 1395mm(i))  
9           is amended by adding at the end the following new  
10          paragraph:

11          “(9) The Secretary may terminate a contract with an  
12          eligible organization under this section or may impose the  
13          intermediate sanctions described in paragraph (6) on the  
14          organization in accordance with formal investigation and  
15          compliance procedures established by the Secretary under  
16          which—

17               “(A) the Secretary provides the organization  
18               with the opportunity to develop and implement a  
19               corrective action plan to correct the deficiencies that  
20               were the basis of the Secretary’s determination  
21               under paragraph (1);

22               “(B) in deciding whether to impose sanctions,  
23               the Secretary considers aggravating factors such as  
24               whether an entity has a history of deficiencies or has

1 not taken action to correct deficiencies the Secretary  
 2 has brought to their attention;

3 “(C) there are no unreasonable or unnecessary  
 4 delays between the finding of a deficiency and the  
 5 imposition of sanctions; and

6 “(D) the Secretary provides the organization  
 7 with reasonable notice and opportunity for hearing  
 8 (including the right to appeal an initial decision) be-  
 9 fore imposing any sanction or terminating the con-  
 10 tract.”.

11 (4) CONFORMING AMENDMENTS.—

12 (A) IN GENERAL.—Section 1876(i)(6)(B)  
 13 of such Act (42 U.S.C. 1395mm(i)(6)(B)) is  
 14 amended by striking the second sentence.

15 (B) PROCEDURAL PROVISIONS.—Section  
 16 1876(i)(6) of such Act (42 U.S.C.  
 17 1395mm(i)(6)) is further amended by adding at  
 18 the end the following new subparagraph:

19 “(D) The provisions of section 1128A (other than  
 20 subsections (a) and (b)) shall apply to a civil money pen-  
 21 alty under subparagraph (A) or (B) in the same manner  
 22 as they apply to a civil money penalty or proceeding under  
 23 section 1128A(a).”.

24 (b) AGREEMENTS WITH PEER REVIEW ORGANIZA-  
 25 TIONS.—

1           (1) REQUIREMENT FOR WRITTEN AGREE-  
2           MENT.—Section 1876(i)(7)(A) of the Social Security  
3           Act (42 U.S.C. 1395mm(i)(7)(A)) is amended by  
4           striking “an agreement” and inserting “a written  
5           agreement”.

6           (2) DEVELOPMENT OF MODEL AGREEMENT.—  
7           Not later than July 1, 1995, the Secretary shall de-  
8           velop a model of the agreement that an eligible orga-  
9           nization with a risk-sharing contract under section  
10          1876 of the Social Security Act must enter into with  
11          an entity providing peer review services with respect  
12          to services provided by the organization under sec-  
13          tion 1876(i)(7)(A) of such Act.

14          (3) REPORT BY GAO.—

15                (A) STUDY.—The Comptroller General of  
16                the United States shall conduct a study of the  
17                costs incurred by eligible organizations with  
18                risk-sharing contracts under section 1876(b) of  
19                such Act of complying with the requirement of  
20                entering into a written agreement with an en-  
21                tity providing peer review services with respect  
22                to services provided by the organization, to-  
23                gether with an analysis of how information gen-  
24                erated by such entities is used by the Secretary

1 to assess the quality of services provided by  
2 such eligible organizations.

3 (B) REPORT TO CONGRESS.—Not later  
4 than July 1, 1997, the Comptroller General  
5 shall submit a report to the Committee on  
6 Ways and Means and the Committee on Energy  
7 and Commerce of the House of Representatives  
8 and the Committee on Finance and the Special  
9 Committee on Aging of the Senate on the study  
10 conducted under subparagraph (A).

11 (c) EFFECTIVE DATE.—The amendments made by  
12 this section shall apply with respect to contract years be-  
13 ginning on or after January 1, 1995.

14 **SEC. 718. EFFECTIVE DATE.**

15 The amendments made by this subtitle shall take ef-  
16 fect January 1, 1995.

17 **Subtitle C—Administrative and**  
18 **Miscellaneous Provisions**

19 **SEC. 721. ESTABLISHMENT OF THE HEALTH CARE FRAUD**  
20 **AND ABUSE DATA COLLECTION PROGRAM.**

21 (a) FINDINGS.—The Congress finds the following:

22 (1) Fraud and abuse with respect to the deliv-  
23 ery of and payment for health care services is a sig-  
24 nificant contributor to the growing costs of the Na-  
25 tion's health care.

1           (2) Control of fraud and abuse in health care  
2       services warrants greater efforts of coordination  
3       than those that can be undertaken by individual  
4       States or the various Federal, State, and local law  
5       enforcement programs.

6           (3) There is a national need to coordinate infor-  
7       mation about health care providers and entities that  
8       have engaged in fraud and abuse in the delivery of  
9       and payment for health care services.

10          (4) There is no comprehensive national data  
11       collection program for the reporting of public infor-  
12       mation about final adverse actions against health  
13       care providers, suppliers, or licensed health care  
14       practitioners that have engaged in fraud and abuse  
15       in the delivery of and payment for health care serv-  
16       ices.

17          (5) A comprehensive national data collection  
18       program for the reporting of public information  
19       about final adverse actions will facilitate the enforce-  
20       ment of the provisions of the Social Security Act and  
21       other statutes applicable to health care fraud and  
22       abuse.

23       (b) GENERAL PURPOSE.—Not later than January 1,  
24   1995, the Secretary shall establish a national health care  
25   fraud and abuse data collection program for the reporting

1 of final adverse actions (not including settlements in which  
2 no findings of liability have been made) against health  
3 care providers, suppliers, or practitioners as required by  
4 subsection (c), with access as set forth in subsection (d).

5 (c) REPORTING OF INFORMATION.—

6 (1) IN GENERAL.—Each government agency  
7 and health care plan shall report any final adverse  
8 action (not including settlements in which no find-  
9 ings of liability have been made) taken against a  
10 health care provider, supplier, or practitioner.

11 (2) INFORMATION TO BE REPORTED.—The in-  
12 formation to be reported under paragraph (1) in-  
13 cludes:

14 (A) The name of any health care provider,  
15 supplier, or practitioner who is the subject of a  
16 final adverse action.

17 (B) The name (if known) of any health  
18 care entity with which a health care provider,  
19 supplier, or practitioner is affiliated or associ-  
20 ated.

21 (C) The nature of the final adverse action.

22 (D) A description of the acts or omissions  
23 and injuries upon which the final adverse action  
24 was based, and such other information as the  
25 Secretary determines by regulation is required

1           for appropriate interpretation of information re-  
2           ported under this section.

3           (3) CONFIDENTIALITY.—In determining what  
4           information is required, the Secretary shall include  
5           procedures to assure that the privacy of individuals  
6           receiving health care services is appropriately pro-  
7           tected.

8           (4) TIMING AND FORM OF REPORTING.—The  
9           information required to be reported under this sub-  
10          section shall be reported regularly (but not less often  
11          than monthly) and in such form and manner as the  
12          Secretary prescribes. Such information shall first be  
13          required to be reported on a date specified by the  
14          Secretary.

15          (5) TO WHOM REPORTED.—The information re-  
16          quired to be reported under this subsection shall be  
17          reported to the Secretary.

18          (d) DISCLOSURE AND CORRECTION OF INFORMA-  
19          TION.—

20               (1) DISCLOSURE.—With respect to the informa-  
21          tion about final adverse actions (not including settle-  
22          ments in which no findings of liability have been  
23          made) reported to the Secretary under this section  
24          respecting a health care provider, supplier, or practi-

1       tioner, the Secretary shall, by regulation, provide  
2       for—

3               (A) disclosure of the information, upon re-  
4               quest, to the health care provider, supplier, or  
5               licensed practitioner, and

6               (B) procedures in the case of disputed ac-  
7               curacy of the information.

8               (2) CORRECTIONS.—Each Government agency  
9       and health care plan shall report corrections of in-  
10      formation already reported about any final adverse  
11      action taken against a health care provider, supplier,  
12      or practitioner, in such form and manner that the  
13      Secretary prescribes by regulation.

14      (e) ACCESS TO REPORTED INFORMATION.—

15              (1) AVAILABILITY.—The information in this  
16      database shall be available to Federal and State gov-  
17      ernment agencies and health care plans pursuant to  
18      procedures that the Secretary shall provide by regu-  
19      lation.

20              (2) FEES FOR DISCLOSURE.—The Secretary  
21      may establish or approve reasonable fees for the dis-  
22      closure of information in this database. The amount  
23      of such a fee may not exceed the costs of processing  
24      the requests for disclosure and of providing such in-  
25      formation. Such fees shall be available to the Sec-



1       retary or, in the Secretary's discretion to the agency  
2       designated under this section to cover such costs.

3       (f) PROTECTION FROM LIABILITY FOR REPORT-  
4       ING.—No person or entity, including the agency des-  
5       ignated by the Secretary in subsection (c)(5) shall be held  
6       liable in any civil action with respect to any report made  
7       as required by this section, without knowledge of the fal-  
8       sity of the information contained in the report.

9       (g) DEFINITIONS AND SPECIAL RULES.—For pur-  
10      poses of this section:

11           (1) The term “final adverse action” includes:

12                   (A) Civil judgments against a health care  
13                   provider in Federal or State court related to the  
14                   delivery of a health care item or service.

15                   (B) Federal or State criminal convictions  
16                   related to the delivery of a health care item or  
17                   service.

18                   (C) Actions by Federal or State agencies  
19                   responsible for the licensing and certification of  
20                   health care providers, suppliers, and licensed  
21                   health care practitioners, including—

22                           (i) formal or official actions, such as  
23                           revocation or suspension of a license (and  
24                           the length of any such suspension), rep-  
25                           rimand, censure or probation,

1 (ii) any other loss of license of the  
2 provider, supplier, or practitioner, by oper-  
3 ation of law, or

4 (iii) any other negative action or find-  
5 ing by such Federal or State agency that  
6 is publicly available information.

7 (D) Exclusion from participation in Fed-  
8 eral or State health care programs.

9 (E) Any other adjudicated actions or deci-  
10 sions that the Secretary shall establish by regu-  
11 lation.

12 (2) The terms “licensed health care practi-  
13 tioner”, “licensed practitioner”, and “practitioner”  
14 mean, with respect to a State, an individual who is  
15 licensed or otherwise authorized by the State to pro-  
16 vide health care services (or any individual who,  
17 without authority holds himself or herself out to be  
18 so licensed or authorized).

19 (3) The term “health care provider” means a  
20 provider of services as defined in section 1861(u) of  
21 the Social Security Act, and any entity, including a  
22 health maintenance organization, group medical  
23 practice, or any other entity listed by the Secretary  
24 in regulation, that provides health care services.

1           (4) The term “supplier” means a supplier of  
2 health care items and services described in section  
3 1819 (a) and (b), and section 1861 of the Social Se-  
4 curity Act.

5           (5) The term “Government agency” shall in-  
6 clude:

7                   (A) The Department of Justice.

8                   (B) The Department of Health and  
9 Human Services.

10                  (C) Any other Federal agency that either  
11 administers or provides payment for the deliv-  
12 ery of health care services, including, but not  
13 limited to the Department of Defense and the  
14 Veterans’ Administration.

15                  (D) State law enforcement agencies.

16                  (E) State medicaid fraud and abuse units.

17                  (F) Federal or State agencies responsible  
18 for the licensing and certification of health care  
19 providers and licensed health care practitioners.

20           (6) The term “health care plan” has the mean-  
21 ing given to such term by section 1128(i) of the So-  
22 cial Security Act.

23           (7) For purposes of paragraph (2), the exist-  
24 ence of a conviction shall be determined under para-

1 graph (4) of section 1128(j) of the Social Security  
2 Act.

3 (h) CONFORMING AMENDMENT.—Section 1921(d) of  
4 the Social Security Act is amended by inserting “and sec-  
5 tion 721 of the America’s Health Care Option Act” after  
6 “section 422 of the Health Care Quality Improvement Act  
7 of 1986”.

## 8 **Subtitle D—Amendments to** 9 **Criminal Law**

### 10 **SEC. 731. HEALTH CARE FRAUD.**

11 (a) IN GENERAL.—

12 (1) FINES AND IMPRISONMENT FOR HEALTH  
13 CARE FRAUD VIOLATIONS.—Chapter 63 of title 18,  
14 United States Code, is amended by adding at the  
15 end the following new section:

#### 16 **“§ 1347. Health care fraud**

17 “(a) Whoever knowingly executes, or attempts to exe-  
18 cute, a scheme or artifice—

19 “(1) to defraud any health care plan or other  
20 person, in connection with the delivery of or pay-  
21 ment for health care benefits, items, or services; or

22 “(2) to obtain, by means of false or fraudulent  
23 pretenses, representations, or promises, any of the  
24 money or property owned by, or under the custody  
25 or control of, any health care plan, or person in con-

1        nection with the delivery of or payment for health  
2        care benefits, items, or services;  
3        shall be fined under this title or imprisoned not more than  
4        10 years, or both. If the violation results in serious bodily  
5        injury (as defined in section 1365(g)(3) of this title), such  
6        person shall be imprisoned for any term of years.

7        “(b) For purposes of this section, the term ‘health  
8        care plan’ means a federally funded public program, or  
9        a private plan or other arrangement for the delivery of  
10       or payment for health care items or services.”.

11                (2) CLERICAL AMENDMENT.—The table of sec-  
12        tions at the beginning of chapter 63 of title 18,  
13        United States Code, is amended by adding at the  
14        end the following:

“1347. Health care fraud.”.

15        (b) CRIMINAL FINES DEPOSITED IN THE ANTI-  
16        FRAUD AND ABUSE TRUST FUND.—The Secretary of the  
17        Treasury shall deposit into the Anti-Fraud and Abuse  
18        Trust Fund established under section 701(b) an amount  
19        equal to the criminal fines imposed under section 1347  
20        of title 18, United States Code (relating to health care  
21        fraud).

1 **SEC. 732. FORFEITURES FOR FEDERAL HEALTH CARE OF-**  
 2 **FENSES.**

3 (a) IN GENERAL.—Section 982(a) of title 18, United  
 4 States Code, is amended by adding after paragraph (5)  
 5 the following new paragraph:

6 “(6)(A) The court, in imposing sentence on a person  
 7 convicted of a Federal health care offense, shall order the  
 8 person to forfeit property, real or personal, that—

9 “(i) is used in the commission of the offense if  
 10 the offense results in a financial loss or gain of  
 11 \$50,000 or more; or

12 “(ii) constitutes or is derived from proceeds  
 13 traceable to the commission of the offense.

14 “(B) For purposes of this paragraph, the term ‘Fed-  
 15 eral health care offense’ means a violation of, or a criminal  
 16 conspiracy to violate—

17 “(i) section 1347 of this title;

18 “(ii) section 1128B of the Social Security Act;

19 “(iii) sections 287, 371, 664, 666, 1001, 1027,  
 20 1341, 1343, or 1954 of this title if the violation or  
 21 conspiracy relates to health care fraud; and

22 “(iv) section 501 or 511 of the Employee Re-  
 23 tirement Income Security Act of 1974, if the viola-  
 24 tion or conspiracy relates to health care fraud.”.

25 (b) PROPERTY FORFEITED DEPOSITED IN ANTI-  
 26 FRAUD AND ABUSE TRUST FUND.—The Secretary of the

1 Treasury shall deposit into the Anti-Fraud and Abuse  
 2 Trust Fund established under section 701(b) an amount  
 3 equal to amounts resulting from forfeiture of property by  
 4 reason of a Federal health care offense pursuant to section  
 5 982(a)(6) of title 18, United States Code.

6 **SEC. 733. INJUNCTIVE RELIEF RELATING TO FEDERAL**  
 7 **HEALTH CARE OFFENSES.**

8 Section 1345(a)(1) of title 18, United States Code,  
 9 is amended—

10 (1) by striking “or” at the end of subparagraph  
 11 (A);

12 (2) by inserting “or” at the end of subpara-  
 13 graph (B); and

14 (3) by adding at the end the following:

15 “(C) committing or about to commit a  
 16 Federal health care offense (as defined in sec-  
 17 tion 982(a)(6)(B) of this title);”.

18 **Subtitle E—Amendments to Civil**  
 19 **False Claims Act**

20 **SEC. 741. AMENDMENTS TO CIVIL FALSE CLAIMS ACT.**

21 (a) IN GENERAL.—Section 3729 of title 31, United  
 22 States Code, is amended—

23 (1) in subsection (a)(7), by inserting “or to a  
 24 health care plan,” after “property to the Govern-  
 25 ment,”;

1           (2) in the matter following subsection (a)(7), by  
2       inserting “or health care plan” before “sustains be-  
3       cause of the act of that person,”;

4           (3) at the end of the first sentence of sub-  
5       section (a), by inserting “or health care plan” before  
6       “sustains because of the act of the person.”;

7           (4) in subsection (c)—

8               (A) by inserting “the term” after “sec-  
9       tion,”; and

10           (B) by adding at the end the following:

11       “The term also includes any request or demand,  
12       whether under contract or otherwise, for money  
13       or property which is made or presented to a  
14       health care plan.”; and

15           (5) by adding at the end the following:

16       “(f) HEALTH CARE PLAN DEFINED.—For purposes  
17       of this section, the term ‘health care plan’ means a feder-  
18       ally funded public program for the delivery of or payment  
19       for health care items or services.”.

20       (b) PENALTIES AND DAMAGES DEPOSITED INTO THE  
21       ANTI-FRAUD AND ABUSE TRUST FUND.—The Secretary  
22       of the Treasury shall deposit into the Anti-Fraud and  
23       Abuse Trust Fund established under section 701(b) an  
24       amount equal to penalties and damages imposed under  
25       section 3729 of title 31, United States Code, in cases in-



1 involving claims related to the provision of health care items  
 2 and services (other than funds awarded to a relator or  
 3 for restitution).

## 4 **TITLE VIII—MEDICARE AND** 5 **MEDICAID**

### 6 **SEC. 800. REFERENCES TO SOCIAL SECURITY ACT.**

7 Except as otherwise specifically provided, whenever in  
 8 this title an amendment is expressed in terms of an  
 9 amendment to or repeal of a section or other provision,  
 10 the reference shall be considered to be made to that sec-  
 11 tion or other provision of the Social Security Act.

## 12 **Subtitle A—Medicare**

### 13 **PART I—INTEGRATION OF MEDICARE**

#### 14 **BENEFICIARIES INTO THE PRIVATE MARKET**

### 15 **SEC. 801. STUDY ON INTEGRATION OF MEDICARE BENE-** 16 **FICIARIES.**

17 (a) IN GENERAL.—The Secretary of Health and  
 18 Human Services (hereafter in this section referred to as  
 19 the “Secretary”) shall study—

20 (1) allowing payment under title XVIII of the  
 21 Social Security Act on behalf of medicare bene-  
 22 ficiaries that opt—

23 (A) to enroll in certified health plans (as  
 24 defined in section 21003(b) of the Social Secu-  
 25 rity Act); and

1 (B) to establish medical savings accounts  
2 (in accordance with section 213 of the Ameri-  
3 ca's Health Care Option Act); and

4 (2) allowing payment under title XVIII of the  
5 Social Security Act on behalf of medicare bene-  
6 ficiaries who are military retirees that opt to enroll  
7 in health plans sponsored by the Department of De-  
8 fense or other appropriate Federal health care pro-  
9 grams.

10 (b) RECOMMENDATIONS.—Not later than 1 year  
11 after the date of the enactment of this Act, the Secretary  
12 shall submit recommendations to Congress on each of the  
13 matters studied under subsection (a).

14 **SEC. 802. IMPROVEMENTS TO RISK CONTRACTS.**

15 (a) RATING AREAS.—Section 1876(a)(1)(F)(ii) (42  
16 U.S.C. 1395mm(a)(1)(F)(ii)) is amended by striking  
17 “county (or equivalent area)” and inserting “Metropolitan  
18 Statistical Area (as defined by the Office of Management  
19 and Budget), New England County Metropolitan Area, or  
20 other appropriate geographic area outside a Metropolitan  
21 Statistical Area or a New England County Metropolitan  
22 Area (hereafter in this section referred to as a ‘rating  
23 area’)”.

24 (b) PERIOD OF ENROLLMENT.—Section 1876(c)(3)  
25 (42 U.S.C. 1395mm(c)(3)) is amended—

1 (1) in subparagraph (A)(i), after “of at least 30  
2 days duration every year”, by inserting “(which may  
3 be specified by the Secretary)”;

4 (2) in subparagraph (B), by striking “as of”  
5 and inserting “, at the option of the organization, (i)  
6 during an annual period as approved by the Sec-  
7 retary, or (ii) as of”;

8 (3) in subparagraph (E)—

9 (A) by striking “and” in clause (iv),

10 (B) by striking the period in clause (v) and  
11 inserting “, and”, and

12 (C) by adding at the end the following new  
13 clause:

14 “(vi) the option chosen by the plan  
15 under clause (i) or (ii) of subparagraph  
16 (B) with respect to termination of enroll-  
17 ment by an individual.”.

18 (c) **MARKETING MATERIALS.**—Section 1876(c)(3)(C)  
19 (42 U.S.C. 1395mm(c)(3)(C)) is amended by adding at  
20 the end the following: “The Secretary shall develop com-  
21 parative materials with respect to all eligible organizations  
22 in an area (and with respect to the program established  
23 under this title for individuals not enrolled with such an  
24 organization) for distribution by such organizations or the

1 Secretary to individuals eligible to enroll under this sec-  
2 tion.”.

3 (d) FIFTY-FIFTY RULE.—Section 1876(f) (42 U.S.C.  
4 1395mm(f)) is amended—

5 (1) by amending paragraph (2) to read as fol-  
6 lows:

7 “(2) The Secretary may modify or waive the re-  
8 quirement imposed by paragraph (1) if an eligible  
9 organization demonstrates that it provides for ade-  
10 quate quality of care for individuals enrolled under  
11 this section by—

12 “(A) meeting the quality standards for or-  
13 ganizations with contracts under this section;

14 “(B) meeting the fiscal soundness require-  
15 ments under this section;

16 “(C) demonstrating successful operational  
17 experience as an eligible organization under this  
18 section for at least the 3 years immediately pre-  
19 ceding an application for a waiver under this  
20 paragraph; and

21 “(D) demonstrating that the number of in-  
22 dividuals enrolled in the plan or its parent orga-  
23 nization is at least 50,000 at the time of appli-  
24 cation for a waiver under this paragraph.

1 In making a determination under subparagraph (A)  
2 with respect to an eligible organization, the Sec-  
3 retary may accept quality performance standards as  
4 measured by private organizations acceptable to the  
5 Secretary or organizations designated by the Sec-  
6 retary, including peer review organizations.”; and

7 (2) by adding at the end the following new  
8 paragraph:

9 “(4) The Secretary may terminate the require-  
10 ment under paragraph (1) when the Secretary deter-  
11 mines that health plans have established alternative  
12 quality assurance mechanisms that effectively pro-  
13 vide sufficient quality safeguards.”.

14 (e) REBATES.—Section 1876(g)(2) (42 U.S.C.  
15 1395mm(g)(2)) is amended in the matter following sub-  
16 paragraph (B) by striking “community rate (as so re-  
17 duced); except” and inserting “community rate (as so re-  
18 duced) or, at the election of the plan, a cash rebate equal  
19 to such difference; except”.

20 (f) DIRECT CALCULATION OF AAPCC.—Section  
21 1876(a)(4) (42 U.S.C. 1395mm(a)(4)) is amended by  
22 striking “actual experience” and all that follows through  
23 “actuarial equivalence)” and inserting “actual experience  
24 in a rating area”.

25 (g) DEMONSTRATION PROJECT.—

1           (1) IN GENERAL.—Not later than 18 months  
2       after the date of the enactment of this Act, the Sec-  
3       retary of Health and Human Services shall establish  
4       a demonstration project under which any eligible or-  
5       ganization that—

6                   (A) has a risk contract under section 1876  
7       of the Social Security Act (42 U.S.C. 1395mm),  
8       and

9                   (B) serves individuals enrolled under such  
10      section in a rating area (as defined under sec-  
11      tion 1876(a)(1)(F)(ii) of such Act),

12      is paid, with respect to such individuals, on the basis  
13      of a payment methodology that blends market-based  
14      premiums and the average per capita fee-for-service  
15      costs for individuals eligible to enroll under such sec-  
16      tion for the area and gives greater weight to market-  
17      based premiums in areas in which a greater propor-  
18      tion of such individuals are enrolled with such orga-  
19      nizations.

20           (2) DESIGNATION OF AREAS.—The Secretary  
21      may designate a rating area (as defined by the Sec-  
22      retary under section 1876(a)(1)(F)(ii) of the Social  
23      Security Act (42 U.S.C. 1395mm(a)(1)(F)(ii))) for  
24      participation in the demonstration established under  
25      paragraph (1) only if—

1 (A) the eligible organizations with a con-  
2 tract under section 1876 of the Social Security  
3 Act serving such area submit an application to  
4 participate in the demonstration project in such  
5 form and manner, and at such time, as the Sec-  
6 retary may designate, and

7 (B)(i) the rating area has more than one  
8 eligible organization with a contract serving  
9 such area,

10 (ii) the rating area has adequate enroll-  
11 ment of individuals who are entitled to benefits  
12 under part A of title XVIII of such Act in eligi-  
13 ble organizations with a contract under section  
14 1876 of such Act (as determined by the Sec-  
15 retary), and

16 (iii) the adjusted average per capita cost  
17 for such rating area for part B services under  
18 title XVIII of such Act as determined in ac-  
19 cordance with such section is less than the  
20 United States per capita cost for part B serv-  
21 ices under such title.

22 (h) EXTENSION OF SOCIAL HEALTH MAINTENANCE  
23 ORGANIZATIONS.—Section 4018(b) of the Omnibus Budg-  
24 et Reconciliation Act of 1987, as amended by section  
25 4207(b)(4)(B) of the Omnibus Budget Reconciliation Act

1 of 1990 and section 13567(a) of the Omnibus Budget Rec-  
2 onciliation Act of 1993, is amended—

3 (1) in paragraph (1), by striking “December  
4 31, 1997” and inserting “December 31, 1999”; and

5 (2) in paragraph (4), by striking “March 31,  
6 1998” and inserting “March 31, 2000”.

7 (i) MILITARY ADJUSTMENT.—Section 1876(a)(1)(B)  
8 (42 U.S.C. 1395mm(a)(1)(B)) is amended by inserting  
9 “use or nonuse of Veteran’s Administration, military  
10 treatment and uniformed services treatment facilities, and  
11 associated physicians, providers, and suppliers,” after  
12 “disability status,”.

13 (j) EFFECTIVE DATE.—The amendments made by  
14 subsections (a), (b), (c), (d), (e), (f), and (i) shall apply  
15 to contracts entered into or renewed on or after January  
16 1, 1996.

17 **SEC. 803. MEDICARE SELECT.**

18 (a) AMENDMENTS TO PROVISIONS RELATING TO  
19 MEDICARE SELECT POLICIES.—

20 (1) PERMITTING MEDICARE SELECT POLICIES  
21 IN ALL STATES.—Subsection (c) of section 4358 of  
22 the Omnibus Budget Reconciliation Act of 1990 is  
23 hereby repealed.



1           (2) REQUIREMENTS OF MEDICARE SELECT  
2       POLICIES.—Section 1882(t)(1) (42 U.S.C.  
3       1395ss(t)(1)) is amended to read as follows:

4       “(1)(A) If a medicare supplemental policy meets the  
5       requirements of the 1991 NAIC Model Regulation or 1991  
6       Federal Regulation and otherwise complies with the re-  
7       quirements of this section except that—

8           “(i) the benefits under such policy are re-  
9       stricted to items and services furnished by certain  
10      entities (or reduced benefits are provided when items  
11      or services are furnished by other entities), and

12          “(ii) in the case of a policy described in sub-  
13      paragraph (C)(i)—

14           “(I) the benefits under such policy are not  
15      one of the groups or packages of benefits de-  
16      scribed in subsection (p)(2)(A),

17           “(II) except for nominal copayments im-  
18      posed for services covered under part B of this  
19      title, such benefits include at least the core  
20      group of basic benefits described in subsection  
21      (p)(2)(B), and

22           “(III) an enrollee’s liability under such pol-  
23      icy for physician’s services covered under part  
24      B of this title is limited to the nominal  
25      copayments described in subclause (II),

1       the policy shall nevertheless be treated as meeting  
2       those requirements if the policy meets the require-  
3       ments of subparagraph (B).

4       “(B) A policy meets the requirements of this sub-  
5 paragraph if—

6           “(i) full benefits are provided for items and  
7       services furnished through a network of entities  
8       which have entered into contracts or agreements  
9       with the issuer of the policy,

10          “(ii) full benefits are provided for items and  
11       services furnished by other entities if the services are  
12       medically necessary and immediately required be-  
13       cause of an unforeseen illness, injury, or condition  
14       and it is not reasonable given the circumstances to  
15       obtain the services through the network,

16          “(iii) the network offers sufficient access,

17          “(iv) the issuer of the policy has arrangements  
18       for an ongoing quality assurance program for items  
19       and services furnished through the network,

20          “(v)(I) the issuer of the policy provides to each  
21       enrollee at the time of enrollment an explanation  
22       of—

23           “(aa) the restrictions on payment under  
24       the policy for services furnished other than by  
25       or through the network,

1           “(bb) out of area coverage under the pol-  
2           icy,

3           “(cc) the policy’s coverage of emergency  
4           services and urgently needed care, and

5           “(dd) the availability of a policy through  
6           the entity that meets the 1991 Model NAIC  
7           Regulation or 1991 Federal Regulation without  
8           regard to this subsection and the premium  
9           charged for such policy, and

10          “(II) each enrollee prior to enrollment acknowl-  
11         edges receipt of the explanation provided under  
12         subclause (I), and

13          “(vi) the issuer of the policy makes available to  
14         individuals, in addition to the policy described in this  
15         subsection, any policy (otherwise offered by the is-  
16         suer to individuals in the State) that meets the 1991  
17         Model NAIC Regulation or 1991 Federal Regulation  
18         and other requirements of this section without re-  
19         gard to this subsection.

20         “(C) (i) A policy described in this subparagraph—

21                 “(I) is offered by an eligible organization (as  
22                 defined in section 1876(b)),

23                 “(II) is not a policy or plan providing benefits  
24                 pursuant to a contract under section 1876 or an ap-  
25                 proved demonstration project described in section

1       603(c) of the Social Security Amendments of 1983,  
2       section 2355 of the Deficit Reduction Act of 1984,  
3       or section 9412(b) of the Omnibus Budget Reconcili-  
4       ation Act of 1986, and

5           “(III) provides benefits which, when combined  
6       with benefits which are available under this title, are  
7       substantially similar to benefits under policies of-  
8       fered to individuals who are not entitled to benefits  
9       under this title.

10       “(ii) In making a determination under subclause (III)  
11      of clause (i) as to whether certain benefits are substan-  
12      tially similar, there shall not be taken into account, except  
13      in the case of preventive services, benefits provided under  
14      policies offered to individuals who are not entitled to bene-  
15      fits under this title which are in addition to the benefits  
16      covered by this title and which are benefits an entity must  
17      provide in order to meet the definition of an eligible orga-  
18      nization under section 1876(b)(1).’”.

19       (b) RENEWABILITY OF MEDICARE SELECT POLI-  
20      CIES.—Section 1882(q)(1) (42 U.S.C. 1395ss(q)(1)) is  
21      amended—

22           (1) by striking “(1) Each” and inserting  
23       “(1)(A) Except as provided in subparagraph (B),  
24       each”;

1           (2) by redesignating subparagraphs (A) and  
2           (B) as clauses (i) and (ii), respectively; and

3           (3) by adding at the end the following new sub-  
4           paragraph:

5           “(B)(i) In the case of a policy that meets the  
6           requirements of subsection (t), an issuer may cancel  
7           or nonrenew such policy with respect to an individ-  
8           ual who leaves the service area of such policy; except  
9           that, if such individual moves to a geographic area  
10          where such issuer, or where an affiliate of such is-  
11          suer, is issuing medicare supplemental policies, such  
12          individual must be permitted to enroll in any medi-  
13          care supplemental policy offered by such issuer or  
14          affiliate that provides benefits comparable to or less  
15          than the benefits provided in the policy being can-  
16          celed or nonrenewed. An individual whose coverage  
17          is canceled or nonrenewed under this subparagraph  
18          shall, as part of the notice of termination or  
19          nonrenewal, be notified of the right to enroll in other  
20          medicare supplemental policies offered by the issuer  
21          or its affiliates.

22          “(ii) For purposes of this subparagraph, the  
23          term ‘affiliate’ shall have the meaning given such  
24          term by the 1991 NAIC Model Regulation.”.

1 (c) CIVIL PENALTY.—Section 1882(t)(2) (42 U.S.C.  
2 1395ss(t)(2)) is amended—

3 (1) by striking “(2)” and inserting “(2)(A)”;

4 (2) by redesignating subparagraphs (A), (B),  
5 (C), and (D) as clauses (i), (ii), (iii), and (iv), re-  
6 spectively;

7 (3) in clause (iv), as redesignated—

8 (A) by striking “paragraph (1)(E)(i)” and  
9 inserting “paragraph (1)(B)(v)(I); and

10 (B) by striking “paragraph (1)(E)(ii)” and  
11 inserting “paragraph (1)(B)(v)(II)”;

12 (4) by striking “the previous sentence” and in-  
13 serting “this subparagraph”; and

14 (5) by adding at the end the following new sub-  
15 paragraph:

16 “(B) If the Secretary determines that an issuer of  
17 a policy approved under paragraph (1) has made a mis-  
18 representation to the Secretary or has provided the Sec-  
19 retary with false information regarding such policy, the  
20 issuer is subject to a civil money penalty in an amount  
21 not to exceed \$100,000 for each such determination. The  
22 provisions of section 1128A (other than the first sentence  
23 of subsection (a) and other than subsection (b)) shall  
24 apply to a civil money penalty under this subparagraph

1 in the same manner as such provisions apply to a penalty  
2 or proceeding under section 1128A(a).”.

3 (d) EFFECTIVE DATES.—

4 (1) NAIC STANDARDS.—If, within 9 months  
5 after the date of the enactment of this Act, the Na-  
6 tional Association of Insurance Commissioners  
7 (hereafter in this subsection referred to as the  
8 “NAIC”) makes changes in the 1991 NAIC Model  
9 Regulation (as defined in section 1882(p)(1)(A) of  
10 the Social Security Act) to incorporate the additional  
11 requirements imposed by the amendments made by  
12 this section, section 1882(g)(2)(A) of such Act shall  
13 be applied in each State, effective for policies issued  
14 to policyholders on and after the date specified in  
15 paragraph (3), as if the reference to the Model Reg-  
16 ulation adopted on June 6, 1979, were a reference  
17 to the 1991 NAIC Model Regulation (as so defined)  
18 as changed under this paragraph (such changed  
19 Regulation referred to in this subsection as the  
20 “1995 NAIC Model Regulation”).

21 (2) SECRETARY STANDARDS.—If the NAIC  
22 does not make changes in the 1991 NAIC Model  
23 Regulation (as so defined) within the 9-month period  
24 specified in paragraph (1), the Secretary of Health  
25 and Human Services (hereafter in this subsection re-

1       ferred to as the “Secretary”) shall promulgate a reg-  
 2       ulation and section 1882(g)(2)(A) of the Social Se-  
 3       curity Act shall be applied in each State, effective  
 4       for policies issued to policyholders on and after the  
 5       date specified in paragraph (3), as if the reference  
 6       to the Model Regulation adopted on June 6, 1979,  
 7       were a reference to the 1991 NAIC Model Regula-  
 8       tion (as so defined) as changed by the Secretary  
 9       under this paragraph (such changed Regulation re-  
 10      ferred to in this subsection as the “1995 Federal  
 11      Regulation”).

12               (3) DATE SPECIFIED.—

13               (A) IN GENERAL.—Subject to subpara-  
 14      graph (B), the date specified in this paragraph  
 15      for a State is the earlier of—

16                   (i) the date the State adopts the 1995  
 17                   NAIC Model Regulation or the 1995 Fed-  
 18                   eral Regulation, or

19                   (ii) 1 year after the date the NAIC or  
 20                   the Secretary first adopts such regulations.

21               (B) ADDITIONAL LEGISLATIVE ACTION RE-  
 22      QUIRED.—In the case of a State which the Sec-  
 23      retary identifies, in consultation with the NAIC,  
 24      as—



(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the 1995 NAIC Model Regulation or the 1995 Federal Regulation, but

(ii) having a legislature which is not scheduled to meet in 1995 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

## **PART II—PROVISIONS RELATED TO PART A**

### **SEC. 811. INPATIENT HOSPITAL SERVICES UPDATE FOR PPS HOSPITALS.**

Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(1) by amending subclause (XII) to read as follows:

1 “(XII) for fiscal years 1997 through 2000, the  
 2 market basket percentage minus 1.0 percentage  
 3 points for hospitals in all areas, and”; and

4 (2) in subclause (XIII), by striking “1998” and  
 5 inserting “2001”.

6 **SEC. 812. REDUCTION IN PAYMENTS FOR CAPITAL-RELAT-**  
 7 **ED COSTS FOR INPATIENT HOSPITAL SERV-**  
 8 **ICES.**

9 (a) REDUCTION IN BASE PAYMENT RATES FOR PPS  
 10 HOSPITALS.—Section 1886(g)(1)(A) (42 U.S.C.  
 11 1395ww(g)(1)(A)) is amended by adding at the end the  
 12 following new sentence: “In addition to the reduction de-  
 13 scribed in the preceding sentence, for discharges occurring  
 14 after September 30, 1995, the Secretary shall reduce by  
 15 7.31 percent the unadjusted standard Federal capital pay-  
 16 ment rate (as described in 42 CFR 412.308(c), as in effect  
 17 on the date of the enactment of the America’s Health Care  
 18 Option Act) and shall reduce by 10.41 percent the  
 19 unadjusted hospital-specific rate (as described in 42 CFR  
 20 412.328(e)(1), as in effect on the date of the enactment  
 21 of the America’s Health Care Option Act).”.

22 (b) REDUCTION IN PAYMENTS FOR PPS-EXEMPT  
 23 HOSPITALS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1))  
 24 is amended by adding at the end the following new sub-  
 25 paragraph:

1       “(T) Such regulations shall provide that, in determin-  
 2       ing the amount of the payments that may be made under  
 3       this title with respect to the capital-related costs of inpa-  
 4       tient hospital services furnished by a hospital that is not  
 5       a subsection (d) hospital (as defined in section  
 6       1886(d)(1)(B)) or a subsection (d) Puerto Rico hospital  
 7       (as defined in section 1886(d)(9)(A)), the Secretary shall  
 8       reduce the amounts of such payments otherwise estab-  
 9       lished under this title by 15 percent for payments attrib-  
 10      utable to portions of cost reporting periods occurring dur-  
 11      ing each of the fiscal years 1996 through 2003.”.

12   **SEC. 813. REVISIONS TO PAYMENT ADJUSTMENTS FOR DIS-**  
 13                   **PROPORTIONATE SHARE HOSPITALS IN PAR-**  
 14                   **TICIPATING STATES.**

15       (a) APPLICATION OF ALTERNATIVE ADJUST-  
 16      MENTS.—Section 1886(d)(5) (42 U.S.C. 1395ww(d)(5)) is  
 17      amended—

18               (1) by redesignating subparagraphs (H) and (I)  
 19               as subparagraphs (I) and (J); and

20               (2) by inserting after subparagraph (G) the fol-  
 21               lowing new subparagraph:

22       “(H)(i) In accordance with this subparagraph, the  
 23      Secretary shall provide for an additional payment for each  
 24      subsection (d) hospital that is located in a participating  
 25      State under the America’s Health Care Option Act during

1 a cost reporting period and that meets the eligibility re-  
2 quirements described in clause (iii).

3 “(ii) The amount of the additional payment made  
4 under clause (i) for each discharge shall be determined  
5 by multiplying—

6 “(I) the sum of the amount determined under  
7 paragraph (1)(A)(ii)(II) (or, if applicable, the  
8 amount determined under paragraph (1)(A)(iii)) and  
9 the amount paid to the hospital under subparagraph  
10 (A) for the discharge, by

11 “(II) the SSI adjustment percentage for the  
12 cost reporting period in which the discharge occurs  
13 (as defined in clause (iv)).

14 “(iii) A hospital meets the eligibility requirements de-  
15 scribed in this clause with respect to a cost reporting pe-  
16 riod if—

17 “(I) in the case of a hospital that is located in  
18 an urban area and that has more than 100 beds, the  
19 hospital’s SSI patient percentage (as defined in  
20 clause (v)) for the cost reporting period is not less  
21 than 5.5 percent;

22 “(II) in the case of a hospital that is located in  
23 an urban area and that has less than 100 beds, the  
24 hospital’s SSI patient percentage is not less than 17  
25 percent;

1           “(III) in the case of a hospital that is classified  
 2           as a rural referral center under subparagraph (C) or  
 3           a sole community hospital under subparagraph (D),  
 4           the hospital’s SSI patient percentage for the cost re-  
 5           porting period is not less than 23 percent; and

6           “(IV) in the case of any other hospital, the hos-  
 7           pital’s SSI patient percentage is not less than 23  
 8           percent.

9           “(iv) For purposes of clause (ii), the ‘SSI adjustment  
 10          percentage’ applicable to a hospital for a cost reporting  
 11          period is equal to—

12           “(I) in the case of a hospital described in clause  
 13          (iii)(I), the percentage determined in accordance  
 14          with the following formula:  $e$  to the  $n$ th power  $- 1$ ,  
 15          where ‘ $e$ ’ is the natural antilog of 1 and where ‘ $n$ ’  
 16          is equal to  $(1.37 * (\text{the hospital’s SSI patient per-}$   
 17          centage for the cost reporting period  $- .055))$ ;

18           “(II) in the case of a hospital described in  
 19          clause (iii)(II) or clause (iii)(IV), 2 percent; and

20           “(III) in the case of a hospital described in  
 21          clause (iii)(III), the sum of 2 percent and .30 per-  
 22          cent of the difference between the hospital’s SSI pa-  
 23          tient percentage for the cost reporting period and 23  
 24          percent.

1       “(v) In this subparagraph, a hospital’s ‘SSI patient  
2 percentage’ with respect to a cost reporting period is equal  
3 to the fraction (expressed as a percentage)—

4               “(I) the numerator of which is the number of  
5 the hospital’s patient days for such period which  
6 were made up of patients who (for such days) were  
7 entitled to benefits under part A and were entitled  
8 to supplementary security income benefits (excluding  
9 State supplementation) under title XVI; and

10              “(II) the denominator of which is the number  
11 of the hospital’s patient days for such period which  
12 were made up of patients who (for such days) were  
13 entitled to benefits under part A.”.

14       (b) NO STANDARDIZATION RESULTING FROM RE-  
15 Duction.—Section 1886(d)(2)(C)(iv) (42 U.S.C.  
16 1395ww(d)(2)(C)(iv)) is amended—

17              (1) by striking “exclude additional payments”  
18 and inserting “adjust such estimate for changes in  
19 payments”;

20              (2) by striking “1989 or” and inserting  
21 “1989,”; and

22              (3) by striking the period at the end and insert-  
23 ing the following: “, or the enactment of section 813  
24 of the America’s Health Care Option Act.”.

1 (c) CONFORMING AMENDMENT.—Section  
 2 1886(d)(5)(F)(i) (42 U.S.C. 1395ww(d)(5)(F)(i)) is  
 3 amended in the matter preceding subclause (I) by insert-  
 4 ing after “hospital” the following: “that is not located in  
 5 a State that is a participating State under the America’s  
 6 Health Care Option Act”.

7 **SEC. 814. MORATORIUM ON DESIGNATION OF NEW LONG-**  
 8 **TERM HOSPITALS.**

9 Effective October 1, 1994, notwithstanding clause  
 10 (iv) of section 1886(d)(1)(B) of the Social Security Act  
 11 (42 U.S.C. 1395ww(d)(1)(B)), a hospital which has an av-  
 12 erage inpatient length of stay (as determined by the Sec-  
 13 retary of Health and Human Services) of greater than 25  
 14 days shall not be treated as a hospital described in such  
 15 clause for purposes of such title unless such hospital was  
 16 treated as a hospital described in such clause for purposes  
 17 of such title as of the date of the enactment of this Act.

18 **SEC. 815. REDUCTION IN ADJUSTMENT FOR INDIRECT MED-**  
 19 **ICAL EDUCATION.**

20 (a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42  
 21 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as fol-  
 22 lows:

23 “(ii) For purposes of clause (i)(II), the indirect  
 24 teaching adjustment factor is equal to  $c * (((1+r)$   
 25  $\text{to the } n\text{th power}) - 1)$ , where ‘r’ is the ratio of the

1 hospital's full-time equivalent interns and residents  
 2 to beds and 'n' equals .405. For discharges occur-  
 3 ring on or after—

4 “(I) May 1, 1986, and before October 1,  
 5 1995, 'c' is equal to 1.89, and

6 “(II) October 1, 1995, 'c' is equal to  
 7 1.65.”.

8 (b) NO RESTANDARDIZATION OF PAYMENT  
 9 AMOUNTS REQUIRED.—Section 1886(d)(2)(C)(i) (42  
 10 U.S.C. 1395ww(d)(2)(C)(i)) is amended by striking “of  
 11 1985” and inserting “of 1985, but not taking into account  
 12 the amendments made by section 816(a) of the America's  
 13 Health Care Option Act”.

14 **SEC. 816. REDUCTION IN ROUTINE SERVICE COST LIMITS**  
 15 **FOR SKILLED NURSING FACILITIES.**

16 (a) PAYMENTS BASED ON COST LIMITS.—Section  
 17 1888(a) (42 U.S.C. 1395yy(a)) is amended by striking  
 18 “112 percent” each place it appears and inserting “106  
 19 percent (adjusted by such amount as the Secretary deter-  
 20 mines to be necessary to preserve the savings resulting  
 21 from the enactment of section 13503(a)(1) of the Omni-  
 22 bus Budget Reconciliation Act of 1993)”.

23 (b) EFFECTIVE DATE.—The amendments made by  
 24 subsection (a) shall apply to cost reporting periods begin-  
 25 ning on or after October 1, 1995.



1     **PART III—PROVISIONS RELATING TO PART B**

2     **SEC. 821. UPDATES FOR PHYSICIANS' SERVICES.**

3         Section 1848(d)(1) (42 U.S.C. 1395w-4(d)(1)) is  
4 amended—

5             (1) in subparagraph (A), by inserting after  
6 “subparagraph (B)” the following: “and, in the case  
7 of 1995, specified in subparagraph (C)”;

8             (2) by redesignating subparagraph (C) as sub-  
9 paragraph (D); and

10            (3) by inserting after subparagraph (B) the fol-  
11 lowing new subparagraph:

12                 “(C) SPECIAL PROVISION FOR 1995.—For  
13 purposes of subparagraph (A), the conversion  
14 factor specified in this subparagraph for 1995  
15 is in the case of physicians' services (not in-  
16 cluded in the category of primary care services  
17 (as defined for purposes of subsection (j)(1))),  
18 the conversion factor established under this  
19 subsection for 1994 reduced by 3 percent and  
20 adjusted by the update established under para-  
21 graph (3) for 1995.”.

1 **SEC. 822. SUBSTITUTION OF REAL GDP TO ADJUST FOR**  
 2 **VOLUME AND INTENSITY; REPEAL OF RE-**  
 3 **STRICTION ON MAXIMUM REDUCTION PER-**  
 4 **MITTED IN DEFAULT UPDATE.**

5 (a) USE OF REAL GDP TO ADJUST FOR VOLUME  
 6 AND INTENSITY.—Section 1848(f)(2)(A)(iii) (42 U.S.C.  
 7 1395w-4(f)(2)(A)(iii)) is amended to read as follows:

8 “(iii) 1 plus the average per capita  
 9 growth in the real gross domestic product  
 10 (divided by 100) for the 5-fiscal-year pe-  
 11 riod ending with the previous fiscal year  
 12 (increased by 1.5 percentage points for the  
 13 category of services consisting of primary  
 14 care services), and”.

15 (b) REPEAL OF RESTRICTION ON MAXIMUM REDUC-  
 16 TION.—Section 1848(d)(3)(B)(ii) (42 U.S.C. 1395w-  
 17 4(d)(3)(B)(ii)) is amended—

18 (1) in the heading, by inserting “IN CERTAIN  
 19 YEARS” after “ADJUSTMENT”;

20 (2) in the matter preceding subclause (I), by  
 21 striking “for a year”;

22 (3) in subclause (I), by adding “and” at the  
 23 end;

24 (4) in subclause (II), by striking “, and” and  
 25 inserting a period; and

26 (5) by striking subclause (III).

1 (c) REPEAL OF PERFORMANCE STANDARD FAC-  
2 TOR.—

3 (1) IN GENERAL.—Section 1848(f)(2) is  
4 amended by striking subparagraph (B) and redesign-  
5 ating subparagraph (C) as subparagraph (B).

6 (2) CONFORMING AMENDMENT.—Section  
7 1848(f)(2)(A) is amended in the matter following  
8 clause (iv) by striking “1, multiplied by 100” and all  
9 that follows through “subparagraph (B))” and in-  
10 serting “1 and multiplied by 100”.

11 (d) EFFECTIVE DATE.—

12 (1) VOLUME PERFORMANCE STANDARDS.—The  
13 amendments made by subsections (a) and (c) shall  
14 apply with respect to volume performance standards  
15 established beginning with fiscal year 1995.

16 (2) REPEAL OF RESTRICTION ON MAXIMUM RE-  
17 Duction.—The amendments made by subsection (b)  
18 shall apply to services furnished on or after January  
19 1, 1997.

20 **SEC. 823. ESTABLISHMENT OF CUMULATIVE EXPENDITURE**  
21 **GOALS FOR PHYSICIAN SERVICES.**

22 (a) USE OF CUMULATIVE PERFORMANCE STAND-  
23 ARD.—Section 1848(f)(2) (42 U.S.C. 1395w-4(f)(2)) is  
24 amended—

25 (1) in subparagraph (A)—

1 (A) in the heading, by striking “IN GEN-  
2 ERAL” and inserting “FISCAL YEARS 1991  
3 THROUGH 1994.—”,

4 (B) in the matter preceding clause (i), by  
5 striking “a fiscal year (beginning with fiscal  
6 year 1991)” and inserting “fiscal years 1991,  
7 1992, 1993, and 1994”, and

8 (C) in the matter following clause (iv), by  
9 striking “subparagraph (B)” and inserting  
10 “subparagraph (C)”;

11 (2) in subparagraph (B), by striking “subpara-  
12 graph (A)” and inserting “subparagraphs (A) and  
13 (B)”;

14 (3) by redesignating subparagraphs (B) and  
15 (C) as subparagraphs (C) and (D); and

16 (4) by inserting after subparagraph (A) the fol-  
17 lowing new subparagraph:

18 “(B) FISCAL YEARS BEGINNING WITH FIS-  
19 CAL YEAR 1995.—Unless Congress otherwise  
20 provides, the performance standard rate of in-  
21 crease, for all physicians’ services and for each  
22 category of physicians’ services, for a fiscal year  
23 beginning with fiscal year 1995 shall be equal  
24 to the performance standard rate of increase

1           determined under this paragraph for the pre-  
2           vious fiscal year, increased by the product of—

3                   “(i) 1 plus the Secretary’s estimate of  
4                   the weighted average percentage increase  
5                   (divided by 100) in the fees for all physi-  
6                   cians’ services or for the category of physi-  
7                   cians’ services, respectively, under this part  
8                   for portions of calendar years included in  
9                   the fiscal year involved,

10                   “(ii) 1 plus the Secretary’s estimate of  
11                   the percentage increase or decrease (di-  
12                   vided by 100) in the average number of in-  
13                   dividuals enrolled under this part (other  
14                   than HMO enrollees) from the previous fis-  
15                   cal year to the fiscal year involved,

16                   “(iii) 1 plus the Secretary’s estimate  
17                   of the average annual percentage growth  
18                   (divided by 100) in volume and intensity of  
19                   all physicians’ services or of the category  
20                   of physicians’ services, respectively, under  
21                   this part for the 5-fiscal-year period ending  
22                   with the preceding fiscal year (based upon  
23                   information contained in the most recent  
24                   annual report made pursuant to section  
25                   1841(b)(2)), and

1           “(iv) 1 plus the Secretary’s estimate  
 2           of the percentage increase or decrease (di-  
 3           vided by 100) in expenditures for all physi-  
 4           cians’ services or of the category of physi-  
 5           cians’ services, respectively, in the fiscal  
 6           year (compared with the previous fiscal  
 7           year) which are estimated to result from  
 8           changes in law or regulations affecting the  
 9           percentage increase described in clause (i)  
 10          and which is not taken into account in the  
 11          percentage increase described in clause (i),  
 12          minus 1, multiplied by 100, and reduced by the  
 13          performance standard factor (specified in sub-  
 14          paragraph (C)).”.

15       (b) TREATMENT OF DEFAULT UPDATE.—

16           (1) IN GENERAL.—Section 1848(d)(3)(B) (42  
 17       U.S.C. 1395w-4(d)(3)(B)) is amended—

18           (A) in clause (i)—

19               (i) in the heading, by striking “IN  
 20               GENERAL” and inserting “1992 THROUGH  
 21               1996”, and

22               (ii) by striking “for a year” and in-  
 23               serting “for 1992, 1993, 1994, 1995, and  
 24               1996”; and

1 (B) by adding after clause (ii) the follow-  
2 ing new clause:

3 “(iii) YEARS BEGINNING WITH 1997.—

4 “(I) IN GENERAL.—The update  
5 for a category of physicians’ services  
6 for a year beginning with 1997 pro-  
7 vided under subparagraph (A) shall be  
8 increased or decreased by the same  
9 percentage by which the cumulative  
10 percentage increase in actual expendi-  
11 tures for such category of physicians’  
12 services for such year was less or  
13 greater, respectively, than the per-  
14 formance standard rate of increase  
15 (established under subsection (f)) for  
16 such category of services for such  
17 year.

18 “(II) CUMULATIVE PERCENTAGE  
19 INCREASE DEFINED.—In subclause  
20 (I), the ‘cumulative percentage in-  
21 crease in actual expenditures’ for a  
22 year shall be equal to the product of  
23 the adjusted increases for each year  
24 beginning with 1995 up to and includ-  
25 ing the year involved, minus 1 and

1 multiplied by 100. In the previous  
 2 sentence, the ‘adjusted increase’ for a  
 3 year is equal to 1 plus the percentage  
 4 increase in actual expenditures for the  
 5 year.”.

6 (2) CONFORMING AMENDMENT.—Section  
 7 1848(d)(3)(A)(i) (42 U.S.C. 1395w-4(d)(3)(A)(i)) is  
 8 amended by striking “subparagraph (B)” and insert-  
 9 ing “subparagraphs (B) and (C)”.

10 **SEC. 824. ESTABLISHMENT OF HOSPITAL OUTPATIENT PRO-**  
 11 **SPECTIVE PAYMENT SYSTEM FOR HOSPITAL**  
 12 **OUTPATIENT DEPARTMENTS.**

13 (a) IN GENERAL.—Section 1833(a)(2)(B) of the So-  
 14 cial Security Act (42 U.S.C. 1395l(a)(2)(B)) is amended  
 15 by striking “section 1886)—” and all that follows and in-  
 16 serting the following: “section 1886), an amount equal to  
 17 a prospectively determined payment rate established by  
 18 the Secretary that provides for payments for such items  
 19 and services to be based upon a national rate adjusted  
 20 to take into account the relative costs of furnishing such  
 21 items and services in various geographic areas, except that  
 22 for items and services furnished during cost reporting pe-  
 23 riods (or portions thereof) beginning on or after January  
 24 1, 1995, such amount shall not exceed 90 percent of the  
 25 amount that would otherwise have been determined under



1 this subparagraph had the amendment made by section  
2 824(a) of the America's Health Care Option Act had not  
3 taken effect;”.

4 (b) ESTABLISHMENT OF PROSPECTIVE PAYMENT  
5 SYSTEM.—Not later than January 1, 1995, the Secretary  
6 of Health and Human Services shall establish the prospec-  
7 tive payment system for hospital outpatient services nec-  
8 essary to carry out section 1833(a)(2)(B) of the Social  
9 Security Act (as amended by subsection (a)). Such pro-  
10 spective payment system shall provide that an individual  
11 have a cost-sharing requirement of 20 percent of the al-  
12 lowable amount on which the prospectively determined  
13 rate for such service is based.

14 (c) EFFECTIVE DATE.—The amendment made by  
15 subsection (a) shall apply to items and services furnished  
16 on or after January 1, 1995.

17 **SEC. 825. GENERAL PART B PREMIUM.**

18 Section 1839(e) (42 U.S.C. 1395r(e)) is amended—

19 (1) in paragraph (1)(A), by striking “and prior  
20 to January 1999”; and

21 (2) in paragraph (2), by striking “prior to Jan-  
22 uary 1998”.

1     **PART IV—PROVISIONS RELATED TO PARTS A**

2                             **AND B**

3     **SEC. 831. MEDICARE SECONDARY PAYER CHANGES.**

4         (a) EXTENSION OF DATA MATCH.—

5             (1) Section 1862(b)(5)(C) (42 U.S.C.  
6     1395y(b)(5)(C)) is amended by striking clause (iii).

7             (2) Section 6103(l)(12) of the Internal Revenue  
8     Code of 1986 is amended by striking subparagraph  
9     (F).

10        (b) REPEAL OF SUNSET ON APPLICATION TO DIS-  
11    ABLED EMPLOYEES OF EMPLOYERS WITH MORE THAN  
12    100 EMPLOYEES.—Section 1862(b)(1)(B)(iii) (42 U.S.C.  
13    1395y(b)(1)(B)(iii)) is amended—

14            (1) in the heading, by striking “SUNSET” and  
15    inserting “EFFECTIVE DATE”; and

16            (2) by striking “, and before October 1, 1998”.

17        (c) EXTENSION OF PERIOD FOR END STAGE RENAL  
18    DISEASE BENEFICIARIES.—Section 1862(b)(1)(C) (42  
19    U.S.C. 1395y(b)(1)(C)) is amended in the second sentence  
20    by striking “and on or before October 1, 1998,”.

21     **SEC. 832. INCREASE IN MEDICARE SECONDARY PAYER COV-**  
22                             **ERAGE FOR END STAGE RENAL DISEASE**  
23                             **SERVICES TO 24 MONTHS.**

24        (a) IN GENERAL.—Section 1862(b)(1)(C) (42 U.S.C.  
25    1395y(b)(1)(C)), as amended by section 831(c), is amend-  
26    ed by striking the last sentence and inserting: “Effective

1 for items and services furnished on or after January 1,  
 2 1996 (with respect to periods beginning on or after July  
 3 1, 1994), this subparagraph shall be applied by substitut-  
 4 ing ‘24-month’ for ‘12-month’ each place it appears.’.

5 (b) EFFECTIVE DATE.—The amendment made by  
 6 subsection (a) shall apply to items and services provided  
 7 on or after January 1, 1996.

8 **SEC. 833. REDUCTION IN ROUTINE COST LIMITS FOR HOME**  
 9 **HEALTH SERVICES.**

10 Section 1861(v)(1)(L)(i) (42 U.S.C.  
 11 1395x(v)(1)(L)(i)) is amended—

12 (1) in subclause (II), by striking “or” at the  
 13 end;

14 (2) in subclause (III), by striking “112 per-  
 15 cent,” and inserting “and before July 1, 1996, 112  
 16 percent, or”; and

17 (3) by inserting after subclause (III) the follow-  
 18 ing new subclause:

19 “(IV) July 1, 1996, 106 percent (adjusted by  
 20 such amount as the Secretary determines to be nec-  
 21 essary to preserve the savings resulting from the en-  
 22 actment of section 13564(a)(1) of the Omnibus  
 23 Budget Reconciliation Act of 1993),”.

1       **Subtitle B—Medicaid Program**

2       **PART I—COORDINATION OF THE MEDICAID PRO-**  
 3       **GRAM WITH REFORMED HEALTH CARE SYS-**  
 4       **TEM**

5       **SEC. 851. STATE PLAN REQUIREMENT REGARDING ELIGI-**  
 6       **BILITY FOR MEDICAL ASSISTANCE.**

7       (a) IN GENERAL.—Section 1902(a) (42 U.S.C.  
 8       1369a(a)), as amended by sections 121 and 201(a), is  
 9       amended—

10               (1) by striking “and” at the end of paragraph  
 11               (63);

12               (2) by striking the period at the end of para-  
 13               graph (64) and inserting “; and ”; and

14               (3) by adding at the end the following new  
 15               paragraph:

16               “(65) provide that the State will continue to  
 17               make eligible for medical assistance under section  
 18               1902(a)(10) any class or category of individuals eli-  
 19               gible for medical assistance under such section as of  
 20               the date of the enactment of the America’s Health  
 21               Care Option Act.”.

22       (b) EFFECTIVE DATE.—The amendment made by  
 23       subsection (a) shall be effective with respect to calendar  
 24       quarters beginning on or after the date of the enactment  
 25       of this Act.

1 **SEC. 852. CAP ON PAYMENTS MADE FOR CERTAIN ACUTE**  
2 **MEDICAL SERVICES FURNISHED UNDER THE**  
3 **MEDICAID PROGRAM.**

4 (a) IN GENERAL.—Title XIX (42 U.S.C. 1396 et  
5 seq.) is amended by redesignating section 1931 as section  
6 1932 and by inserting after section 1930 the following new  
7 section:

8 “CAP ON PAYMENTS MADE FOR CERTAIN ACUTE MEDICAL  
9 SERVICES

10 “SEC. 1931. (a) FEDERAL CAP.—

11 “(1) IN GENERAL.—Notwithstanding any provi-  
12 sion of this part, the amount of any payment to a  
13 State under section 1903(a)(1) with respect to ex-  
14 penditures made by a State for furnishing acute  
15 medical services (as defined in subsection (c)(1)) of  
16 the type included in the FedMed benefits package  
17 (as described in section 21115(b)) to integration eli-  
18 gible individuals (as defined in subsection (c)(2)) in  
19 any calendar quarter shall not be in excess of the  
20 amount determined under paragraph (2) for the  
21 quarter.

22 “(2) AMOUNT DETERMINED.—The amount de-  
23 termined under this paragraph for a quarter is an  
24 amount equal to  $\frac{1}{4}$  of the product of—

25 “(A) the State’s Federal medical assist-  
26 ance percentage (as defined in section 1905(b))

1 of the weighted average maximum premium  
 2 subsidy amount (as defined in subsection  
 3 (c)(4)) for the State for the year; multiplied by

4 “(B) the average number of integration eli-  
 5 gible individuals receiving medical assistance  
 6 under the State plan consisting of acute medi-  
 7 cal services of the type included in the FedMed  
 8 benefits package in any month in the quarter.

9 “(b) STATE CAP.—

10 “(1) IN GENERAL.—Notwithstanding any provi-  
 11 sion of this part, a State shall not be obligated to  
 12 expend an amount in excess of the amount deter-  
 13 mined under paragraph (2) in any calendar quarter  
 14 for furnishing acute medical services of the type in-  
 15 cluded in the FedMed benefits package to integra-  
 16 tion eligible individuals.

17 “(2) AMOUNT DETERMINED.—The amount de-  
 18 termined under this paragraph for a quarter is an  
 19 amount equal to  $\frac{1}{4}$  of the product of—

20 “(A) the State matching percentage (as de-  
 21 fined in subsection (a)(3)) of weighted average  
 22 maximum premium subsidy amount for the  
 23 State for the year; multiplied by

24 “(B) the average number of integration eli-  
 25 gible individuals receiving medical assistance

1 under the State plan consisting of acute medi-  
2 cal services of the type included in the FedMed  
3 benefits package in any month in the quarter.

4 “(c) DEFINITIONS.—

5 “(1) ACUTE MEDICAL SERVICES.—The term  
6 ‘acute medical services’ means items and services de-  
7 scribed in section 1905(a) other than the following:

8 “(A) Nursing facility services (as defined  
9 in section 1905(f)).

10 “(B) Intermediate care facility for the  
11 mentally retarded services (as defined in section  
12 1905(d)).

13 “(C) Personal care services (as described  
14 in section 1905(a)(24)).

15 “(D) Private duty nursing services (as re-  
16 ferred to in section 1905(a)(8)).

17 “(E) Home or community-based services  
18 furnished under a waiver granted under sub-  
19 section (c), (d), or (e) of section 1915.

20 “(F) Home and community care furnished  
21 to functionally disabled elderly individuals  
22 under section 1929.

23 “(G) Community supported living arrange-  
24 ments services under section 1930.

1           “(H) Case-management services (as de-  
2           scribed in section 1915(g)(2)).

3           “(I) Home health care services (as referred  
4           to in section 1905(a)(7)), clinic services, and re-  
5           habilitation services that are furnished to an in-  
6           dividual who has a condition or disability that  
7           qualifies the individual to receive any of the  
8           services described in a previous subparagraph.

9           “(J) Services furnished in an institution  
10          for mental diseases (as defined in section  
11          1905(i)).

12          “(2) INTEGRATION ELIGIBLE INDIVIDUAL.—  
13          The term ‘integration eligible individual’ means, with  
14          respect to any calendar quarter, an individual who  
15          would not be eligible for medical assistance consist-  
16          ing of acute medical services of the type included in  
17          the FedMed benefits package if the provisions of  
18          section 1932(a) were in effect during such quarter.

19          “(3) STATE MATCHING PERCENTAGE.—The  
20          term ‘State matching percentage’ means, with re-  
21          spect to a State, the amount (expressed as a per-  
22          centage) equal to 1 minus the State’s Federal medi-  
23          cal assistance percentage.

24          “(4) WEIGHTED AVERAGE MAXIMUM PREMIUM  
25          SUBSIDY AMOUNT.—



1           “(A) IN GENERAL.—The term ‘weighted  
2           average maximum premium subsidy amount’  
3           for a State for a year means an amount equal  
4           to—

5                   “(i) the sum of—

6                           “(I) the amount determined  
7                           under subparagraph (B) for each  
8                           community-rating area in the State;  
9                           multiplied by

10                           “(II) the number of individuals  
11                           in such community rating area; di-  
12                           vided by

13                           “(ii) the total number of individuals in  
14           the State.

15           “(B) WEIGHTED AVERAGE MAXIMUM SUB-  
16           SIDY AMOUNT IN A COMMUNITY-RATING  
17           AREA.—The weighted average maximum sub-  
18           sidy amount in a community-rating area is an  
19           amount equal to—

20                   “(i) the sum of—

21                           “(I) the weighted average age ad-  
22                           justed maximum subsidy amount for  
23                           an enrollment class (as determined  
24                           under subparagraph (C)) in the com-  
25                           munity-rating area; multiplied by

1 “(II) the number of individuals  
 2 in the enrollment class in the commu-  
 3 nity-rating area; divided by

4 “(ii) the total number of individuals in  
 5 the community-rating area.

6 “(C) WEIGHTED AVERAGE AGE ADJUSTED  
 7 MAXIMUM SUBSIDY AMOUNT FOR AN ENROLL-  
 8 MENT CLASS.—The weighted average age ad-  
 9 justed maximum subsidy amount for an enroll-  
 10 ment class is an amount equal to—

11 “(i) the sum of—

12 “(I) the age adjusted maximum  
 13 subsidy amount determined under sec-  
 14 tion 1952(b)(2)) for each category of  
 15 primary insurer in the enrollment  
 16 class; multiplied by

17 “(II) the number of individuals  
 18 in each category; divided by

19 “(ii) the total number of individuals in  
 20 all such categories.”.

21 (b) EFFECTIVE DATE.—The amendment made by  
 22 subsection (a) shall be effective with respect to calendar  
 23 quarters beginning on or after January 1, 1997.

1 **SEC. 853. INTEGRATION OF CERTAIN MEDICAID ELIGIBLES**  
 2 **INTO REFORMED HEALTH CARE SYSTEM**  
 3 **THROUGH STATE PREMIUM ASSISTANCE**  
 4 **PROGRAM.**

5 (a) IN GENERAL.—Title XIX (42 U.S.C. 1396 et  
 6 seq.), as amended by section 852, is amended by redesignig-  
 7 nating section 1932 as section 1933 and by inserting after  
 8 section 1931 the following new section:

9 “INTEGRATION OF CERTAIN MEDICAID ELIGIBLES INTO  
 10 REFORMED HEALTH CARE SYSTEM

11 “SEC. 1932. (a) IN GENERAL.—

12 “(1) REQUIREMENT ON STATES.—With respect  
 13 to calendar quarters beginning on or after January  
 14 1, 2000, a State with a State plan under this part—

15 “(A) shall not furnish medical assistance  
 16 consisting of acute medical services described in  
 17 section 1931(b)(1) to any individuals not de-  
 18 scribed in subsection (b) who are otherwise eli-  
 19 gible for medical assistance under the plan; and

20 “(B) shall integrate such individuals into  
 21 the State’s premium assistance program under  
 22 part B.

23 “(2) STATE OPTION.—

24 “(A) IN GENERAL.—For 1997, 1998, and  
 25 1999, a State may elect to integrate individuals  
 26 into the State’s premium assistance program

under part B as described in paragraph (1) if the State notifies the Secretary of such election not later than October 1 of the year preceding the year the State intends to begin such integration.

“(B) STATES FURNISHING SERVICES UNDER A WAIVER.—If a State making an election under subparagraph (A) is furnishing medical assistance consisting of acute medical services described in section 1931(b)(1) under a waiver under section 1115 granted on or before December 31, 1996, to individuals who would otherwise be integrated into the State’s premium assistance program, such State may continue to furnish such services to such individuals until the earlier of the termination of the waiver by the State or the Secretary or January 1, 2000.

“(b) INDIVIDUALS DESCRIBED.—The individuals described in this subsection are—

“(1) SSI-eligible individuals (as defined in section 1933(d)(2));

“(2) individuals who are eligible for benefits under part A of title XVIII; and

1           “(3) certain aliens with respect to whom emer-  
2           gency services are furnished under section  
3           1903(v)(2).

4           “(c) STATE MAINTENANCE OF EFFORT.—

5           “(1) IN GENERAL.—

6           “(A) REDUCTION IN QUARTERLY PAY-  
7           MENTS.—For any calendar quarter in an inte-  
8           gration year (as defined in subparagraph (B)),  
9           the amount otherwise payable to a State under  
10          section 1903 for the quarter shall be reduced by  
11          the State maintenance of effort amount for the  
12          quarter determined under paragraph (2).

13          “(B) INTEGRATION YEAR.—For purposes  
14          of this paragraph, the term ‘integration year’  
15          means the first year that the State integrates  
16          individuals into the State’s premium assistance  
17          program under part B and any succeeding year.

18          “(2) MAINTENANCE OF EFFORT AMOUNT.—

19          “(A) IN GENERAL.—The maintenance of  
20          effort amount for a State for a calendar quarter  
21          in an integration year shall be equal to 25 per-  
22          cent of the State’s base payment amount (de-  
23          termined under subparagraph (B)) updated by  
24          the percentage change in the inflation index de-  
25          scribed in subparagraph (C)(i) and the State

1 population index described in subparagraph  
2 (C)(ii) during the period beginning on January  
3 1 of the first integration year and ending on  
4 December 31 of the applicable integration year  
5 (as determined by the Secretary).

6 “(B) STATE BASE PAYMENT AMOUNT.—

7 The base payment amount for a State for an  
8 integration year shall be an amount, as deter-  
9 mined by the Secretary, equal to the total ex-  
10 penditures from State funds made under the  
11 State plan during the year preceding the first  
12 integration year with respect to medical assist-  
13 ance consisting of acute medical services of the  
14 type included in the FedMed benefits package  
15 (as described in section 21115(b)) furnished to  
16 individuals who would not have received such  
17 assistance if the provisions of subsection (a)  
18 were in effect during such year.

19 “(C) INDEXES DESCRIBED.—

20 “(i) INFLATION INDEX.—The Sec-  
21 retary shall establish an index which meas-  
22 ures the percentage change in the weighted  
23 average maximum premium subsidy  
24 amount (as defined in section 1931(c)(4))  
25 for the State from year to year.

1                   “(ii) STATE POPULATION INDEX.—

2                   The Secretary shall establish a State popu-  
3                   lation index which measures the change in  
4                   the number of individuals residing in a  
5                   State from year to year.”

6           (b) NO FEDERAL FINANCIAL PARTICIPATION.—Sec-  
7   tion 1903(i) (42 U.S.C. 1396b(i)) is amended—

8                   (1) by striking “or” at the end of paragraph  
9                   (14),

10                  (2) by striking the period at the end of para-  
11                  graph (15) and inserting “; or”, and

12                  (3) by inserting after paragraph (15) the fol-  
13                  lowing new paragraph:

14                   “(16) with respect any medical assistance con-  
15                   sisting of acute medical services described in section  
16                   1931(b) furnished to individuals who are not de-  
17                   scribed in section 1932(b).”.

18           (c) EFFECTIVE DATE.—The amendments made by  
19   this section shall be effective with respect calendar quar-  
20   ters beginning on or after January 1, 1997.

21   **SEC. 854. STATE PROGRAMS FOR PROVIDING SUPPLE-**  
22                   **MENTAL BENEFITS.**

23           (a) MEDICAID STATE PLAN REQUIREMENT.—Section  
24   1902(a) of the Social Security Act (42 U.S.C. 1396a(a)),

1 as amended by sections 121, 201(a), and 851, is amend-  
2 ed—

3 (1) by striking “and” at the end of paragraph  
4 (64);

5 (2) by striking the period at the end of para-  
6 graph (65) and inserting “; and”; and

7 (3) by adding at the end the following new  
8 paragraph:

9 “(66) provide for a State program furnishing  
10 supplemental benefits in accordance with part C.”.

11 (b) STATE PROGRAMS FOR SUPPLEMENTAL BENE-  
12 FITS.—Title XIX (42 U.S.C. 1396 et seq.), as amended  
13 by section 121, is amended by adding at the end the fol-  
14 lowing new part:

15 **“PART C—STATE PROGRAMS FOR**  
16 **SUPPLEMENTAL BENEFITS**

17 **“SEC. 1961. REQUIREMENT TO OPERATE STATE PROGRAM.**

18 “(a) IN GENERAL.—A State with a State plan ap-  
19 proved under part A shall have in effect a program for  
20 furnishing supplemental benefits (as defined in section  
21 1962(c)) in accordance with this part in calendar years  
22 beginning after 1996.

23 “(b) DESIGNATION OF STATE AGENCY.—A State  
24 may designate any appropriate State agency to administer  
25 the program under this part.



1 **“SEC. 1962. PROGRAM DESCRIBED.**

2 “(a) IN GENERAL.—A State program under this part  
3 shall furnish supplemental benefits to such classes and  
4 categories of the individuals eligible for premium assist-  
5 ance under part B as determined appropriate by the State.

6 “(b) PRIORITIES.—A State may give priority to chil-  
7 dren, pregnant women, and individuals residing in medi-  
8 cally underserved areas in furnishing services under this  
9 part.

10 “(c) SUPPLEMENTAL BENEFITS DEFINED.—The  
11 term ‘supplemental benefits’ means the acute medical  
12 services described in section 1931(b) that—

13 “(1) were furnished under the State plan in the  
14 year preceding the first year that the State inte-  
15 grates individuals into the State’s premium assist-  
16 ance program under part B in accordance with sec-  
17 tion 1932(a); and

18 “(2) are not included in the items and services  
19 provided under the FedMed benefits package (as de-  
20 scribed in 21115(b)).

21 **“SEC. 1963. PAYMENTS TO STATES.**

22 “From its allotment under section 1964(b), the Sec-  
23 retary shall pay to each State for each quarter beginning  
24 with the quarter commencing January 1, 1997, an amount  
25 equal to—

1           “(1) an amount equal to the State’s Federal  
 2           medical assistance percentage (as defined in section  
 3           1905(b)) of the amount demonstrated by State  
 4           claims to have been expended during the quarter for  
 5           furnishing services to eligible individuals under this  
 6           part; plus

7           “(2) an amount equal to 50 percent of the re-  
 8           mainder of the amounts expended during the quar-  
 9           ter as found necessary by the Secretary for the prop-  
 10          er and efficient administration of the State program.

11 **“SEC. 1964. FUNDING.**

12          “(a) IN GENERAL.—The total amount of Federal  
 13          funds available for State programs under this part for  
 14          each fiscal year is—

15               “(1) for fiscal year 1997, \$12,000,000,000; and

16               “(2) for succeeding fiscal years, the amount de-  
 17          termined under this subsection for the preceding fis-  
 18          cal year updated by the estimated percentage change  
 19          in the inflation index described in section  
 20          1932(c)(2)(C)(i) and the State population index de-  
 21          scribed in section 1932(c)(2)(C)(ii).

22          “(b) ALLOTMENTS TO STATES.—

23               “(1) IN GENERAL.—The Secretary shall allot  
 24          the amounts available under subsection (a) for the  
 25          fiscal year to the States in accordance with an allo-

1 cation formula developed by the Secretary which  
2 takes into account—

3 “(A) the percentage of all individuals with  
4 incomes at or below 150 percent of the official  
5 poverty line (as defined in section 1957(6)) in  
6 all States that reside in a particular State; and

7 “(B) a State’s matching percentage (as de-  
8 fined in section 1932(c)(4)(B)).

9 “(2) REALLOCATIONS.—Any amounts allotted  
10 to States under this subsection for a year that are  
11 not expended in such year shall remain available for  
12 State programs under this part and may be reallo-  
13 cated to States as the Secretary determines appro-  
14 priate.

15 “(c) STATE ENTITLEMENT.—This part constitutes  
16 budget authority in advance of appropriations Acts, and  
17 represents the obligation of the Federal Government to  
18 provide for the payment to States of amounts described  
19 in subsection (a).”.

20 (c) CONFORMING AMENDMENTS.—Title XIX (42  
21 U.S.C. 1396 et seq.), as amended by section 121, is  
22 amended by striking the title and inserting the following:

1 **“TITLE XIX—MEDICAL ASSIST-**  
 2 **ANCE PROGRAMS, STATE**  
 3 **PROGRAMS FOR PREMIUM**  
 4 **ASSISTANCE, AND STATE**  
 5 **PROGRAMS FOR SUPPLE-**  
 6 **MENTAL BENEFITS”.**

7 **SEC. 855. OPTIONAL COVERAGE UNDER CERTIFIED**  
 8 **HEALTH PLANS OF SSI-ELIGIBLE INDIVID-**  
 9 **UALS.**

10 (a) STATE OPTION.—Section 1902(a) (42 U.S.C.  
 11 1396a(a)), as amended by sections 121, 201(a), 851, and  
 12 854, is amended—

13 (1) by striking “and” at the end of paragraph  
 14 (65);

15 (2) by striking the period at the end of para-  
 16 graph (66) and inserting “; and”; and

17 (3) by adding at the end the following new  
 18 paragraph:

19 “(67) at the option of the State, provide that  
 20 a SSI-eligible individual (as defined in section  
 21 1933(d)) has the option to receive medical assistance  
 22 consisting of the items or services covered under the  
 23 FedMed benefits package (as described in section  
 24 21115(b)) through enrollment with a certified health  
 25 plan (as defined in 21003(b)) providing such pack-

1 age instead of through enrollment in the State plan,  
2 in accordance with the requirements of section  
3 1933.”.

4 (b) REQUIREMENTS DESCRIBED.—Title XIX (42  
5 U.S.C. 1396 et seq.) is amended by redesignating section  
6 1933 as section 1934 and by inserting after section 1932  
7 the following new section:

8 “REQUIREMENTS FOR STATES PROVIDING OPTIONAL COV-  
9 ERAGE UNDER CERTIFIED HEALTH PLANS TO SSI-  
10 ELIGIBLE INDIVIDUALS

11 “SEC. 1933. (a) IN GENERAL.—For purposes of sec-  
12 tion 1902(a)(67), a State meets the requirements of this  
13 section with respect to SSI-eligible individuals if the State  
14 meets the following requirements:

15 “(1) CHOICE OF PLANS.—The State must offer  
16 individuals a choice of a certified health plans under  
17 such section, except that nothing in this paragraph  
18 may be construed to waive any limits on the capacity  
19 of a certified health plan applicable under title XXI.

20 “(2) INFORMED CHOICE.—The State shall en-  
21 sure that each SSI-eligible individual is provided suf-  
22 ficient information to make an informed choice  
23 about enrolling in a certified health plan under such  
24 section and selecting such a plan.

25 “(3) PAYMENTS TO CERTIFIED HEALTH PLANS  
26 BY STATES.—The State shall make all necessary

1        payments of premiums, copayments, and deductibles  
2        applicable under a certified health plan on behalf of  
3        a SSI-eligible individual who enrolls in a certified  
4        health plan under such section.

5        “(b) TREATMENT OF PAYMENTS AS MEDICAL AS-  
6        SISTANCE.—For purposes of determining the amount of  
7        Federal financial participation for a State under section  
8        1903 in a quarter, any payments made by a State under  
9        subsection (a)(3) shall be treated as expenditures for med-  
10       ical assistance under the State plan for such quarter.

11       “(c) LIMITATION ON NUMBER OF INDIVIDUALS PER-  
12       MITTED TO MAKE ELECTION.—

13                “(1) IN GENERAL.—

14                        “(A) LIMITATION.—The number of SSI-el-  
15                        igible individuals electing to enroll in a certified  
16                        health plan under section 1902(a)(67) in a  
17                        State during a year may not exceed the applica-  
18                        ble percentage determined under subparagraph  
19                        (B) of the Secretary’s estimate of the number  
20                        of such individuals in the State who are eligible  
21                        to enroll in certified health plans under such  
22                        section during the year.

23                        “(B) APPLICABLE PERCENTAGE DE-  
24                        SCRIBED.—The ‘applicable percentage’ deter-

1           mined under this subparagraph with respect to  
2           a State for a year—

3                   “(i) for each of the first 3 years for  
4                   which the State exercises the option de-  
5                   scribed in such section, 15 percent; and

6                   “(ii) for each succeeding year for  
7                   which the State exercises such option, the  
8                   applicable percentage under this subpara-  
9                   graph for the preceding year, increased by  
10                  10 percent.

11               “(2) WAIVER OF LIMITATION.—The limit on  
12               the number of individuals provided in paragraph (1)  
13               may be waived by the Secretary with respect to a  
14               State if the Secretary determines that such a waiver  
15               is appropriate.

16               “(d) DEFINITIONS.—

17                   “(1) CERTIFIED HEALTH PLAN.—The term  
18                   ‘certified health plan’ means a certified health plan  
19                   (as defined in section 21003(b)) that provides a  
20                   FedMed benefits package (as described in section  
21                   21115(b)).

22                   “(2) SSI-ELIGIBLE INDIVIDUAL.—The term  
23                   ‘SSI-eligible individual’ means an individual who is  
24                   eligible for medical assistance under the State plan  
25                   and—

1           “(A) with respect to whom supplemental  
2 security income benefits are being paid under  
3 title XVI,

4           “(B) who is receiving a supplementary  
5 payment under section 1616 or under section  
6 212 of Public Law 93–66, or

7           “(C) who is receiving monthly benefits  
8 under section 1619(a) (whether or not pursuant  
9 to section 1616(c)(3)).”.

10       (c) EFFECTIVE DATE.—The amendments made by  
11 this section shall be effective with respect to calendar  
12 quarters beginning on or after January 1, 1997.

13       **PART II—STATE ELIGIBILITY TO CONTRACT FOR**  
14               **COORDINATED CARE SERVICES**

15       **SEC. 861. MODIFICATION OF FEDERAL REQUIREMENTS TO**  
16               **ALLOW STATES MORE FLEXIBILITY IN CON-**  
17               **TRACTING FOR COORDINATED CARE SERV-**  
18               **ICES UNDER MEDICAID.**

19       (a) IN GENERAL.—

20           (1) PAYMENT PROVISIONS.—Section 1903(m)  
21       (42 U.S.C. 1396b(m)) is amended to read as follows:

22       “(m)(1) No payment shall be made under this title  
23 to a State with respect to expenditures incurred by such  
24 State for payment to an entity which is at risk (as defined  
25 in section 1931(a)(4)) for services provided by such entity



1 to individuals eligible for medical assistance under the  
 2 State plan under this title, unless the entity is a risk con-  
 3 tracting entity (as defined in section 1931(a)(3)) and the  
 4 State and such entity comply with the applicable provi-  
 5 sions of section 1931.

6 “(2) No payment shall be made under this title to  
 7 a State with respect to expenditures incurred by such  
 8 State for payment for services provided to an individual  
 9 eligible for medical assistance under the State plan under  
 10 this title if such payment by the State is contingent upon  
 11 the individual receiving such services from a specified  
 12 health care provider or subject to the approval of a speci-  
 13 fied health care provider, unless the entity receiving pay-  
 14 ment is a primary care case management entity (as de-  
 15 fined in section 1931(a)(2)) and the State and such entity  
 16 comply with the applicable provisions of section 1931.”.

17 (2) REQUIREMENTS FOR COORDINATED CARE  
 18 SERVICES.—Title XIX (42 U.S.C. 1396 et seq.) is  
 19 amended by adding at the end the following new sec-  
 20 tion:

21 “REQUIREMENTS FOR COORDINATED CARE SERVICES

22 “SEC. 1931. (a) DEFINITIONS.—For purposes of this  
 23 title—

24 “(1) PRIMARY CARE CASE MANAGEMENT PRO-  
 25 GRAM.—The term ‘primary care case management  
 26 program’ means a program operated by a State

1 agency under which such State agency enters into  
2 contracts with primary care case management enti-  
3 ties for the provision of health care items and serv-  
4 ices which are specified in such contracts and the  
5 provision of case management services to individuals  
6 who are—

7 “(A) eligible for medical assistance under  
8 the State plan,

9 “(B) enrolled with such primary care case  
10 management entities, and

11 “(C) entitled to receive such specified  
12 health care items and services and case man-  
13 agement services only as approved and ar-  
14 ranged for, or provided, by such entities.

15 “(2) PRIMARY CARE CASE MANAGEMENT EN-  
16 TITY.—The term ‘primary care case management  
17 entity’ means a health care provider which—

18 “(A) must be a physician, group of physi-  
19 cians, a Federally qualified health center, a  
20 rural health clinic, or an entity employing or  
21 having other arrangements with physicians op-  
22 erating under a contract with a State to provide  
23 services under a primary care case management  
24 program,

1           “(B) receives payment on a fee for service  
2           basis (or, in the case of a Federally qualified  
3           health center or a rural health clinic, on a rea-  
4           sonable cost per encounter basis) for the provi-  
5           sion of health care items and services specified  
6           in such contract to enrolled individuals,

7           “(C) receives an additional fixed fee per  
8           enrollee for a period specified in such contract  
9           for providing case management services (includ-  
10          ing approving and arranging for the provision  
11          of health care items and services specified in  
12          such contract on a referral basis) to enrolled in-  
13          dividuals, and

14          “(D) is not an entity that is at risk (as de-  
15          fined in paragraph (4)) for such case manage-  
16          ment services.

17          “(3) RISK CONTRACTING ENTITY.—The term  
18          ‘risk contracting entity’ means an entity, including a  
19          certified health plan (as defined in section 21003(b))  
20          that provides a FedMed benefits package (as de-  
21          scribed in section 21115(b)), which has a contract  
22          with the State agency (or a health insuring organi-  
23          zation described in subsection (l)(2)) under which  
24          the entity—

1           “(A) provides or arranges for the provision  
2 of health care items or services which are speci-  
3 fied in such contract to individuals eligible for  
4 medical assistance under the State plan, and

5           “(B) is at risk (as defined in paragraph  
6 (4)) for part or all of the cost of such items or  
7 services furnished to individuals eligible for  
8 medical assistance under such plan.

9           “(4) AT RISK.—The term ‘at risk’ means an  
10 entity which—

11           “(A) has a contract with the State agency  
12 under which such entity is paid a fixed amount  
13 for providing or arranging for the provision of  
14 health care items or services specified in such  
15 contract to an individual eligible for medical as-  
16 sistance under the State plan and enrolled with  
17 such entity, regardless of whether such items or  
18 services are furnished to such individual, and

19           “(B) is liable for all or part of the cost of  
20 furnishing such items or services, regardless of  
21 whether such cost exceeds such fixed payment.

22           “(5) FEDERALLY QUALIFIED HEALTH CEN-  
23 TER.—The term ‘Federally qualified health center’  
24 means a Federally qualified health center as defined  
25 in section 1905(l)(2)(B).

1           “(6) RURAL HEALTH CLINIC.—The term ‘rural  
2       health clinic’ means a rural health clinic as defined  
3       in section 1905(l)(1).

4           “(b) GENERAL REQUIREMENTS FOR RISK CON-  
5       TRACTING ENTITIES.—

6           “(1) ORGANIZATION.—A risk contracting entity  
7       meets the requirements of this section only if such  
8       entity—

9           “(A)(i) is a qualified health maintenance  
10       organization as defined in section 1310(d) of  
11       the Public Health Service Act, as determined by  
12       the Secretary pursuant to section 1312 of such  
13       Act; or

14          “(ii) is described in subparagraph (C), (D),  
15       (E), (F), or (G) of subsection (e)(4);

16          “(B) is a Federally qualified health center  
17       or a rural health clinic which has made ade-  
18       quate provision against the risk of insolvency  
19       (pursuant to the guidelines and regulations is-  
20       sued by the Secretary under this section), and  
21       ensures that individuals eligible for medical as-  
22       sistance under the State plan are not held liable  
23       for such entity’s debts in case of such entity’s  
24       insolvency; or

1           “(C) is an entity which meets all applicable  
2           State licensing requirements and has made ade-  
3           quate provision against the risk of insolvency  
4           (pursuant to the guidelines and regulations is-  
5           sued by the Secretary under this section), and  
6           ensures that individuals eligible for medical as-  
7           sistance under the State plan are not held liable  
8           for such entity’s debts in case of such entity’s  
9           insolvency.

10          “(2) GUARANTEES OF ENROLLEE ACCESS.—A  
11          risk contracting entity meets the requirements of  
12          this section only if—

13               “(A) the geographic locations, hours of op-  
14               eration, patient to staff ratios, and other rel-  
15               evant characteristics of such entity are suffi-  
16               cient to afford individuals eligible for medical  
17               assistance under the State plan access to such  
18               entities that is at least equivalent to the access  
19               to health care providers that would be available  
20               to such individuals if such individuals were not  
21               enrolled with such entity;

22               “(B) such entity has reasonable and ade-  
23               quate hours of operation, including 24-hour  
24               availability of—

1           “(i)(I) treatment for an unforeseen ill-  
2           ness, injury, or condition of an individual  
3           eligible for medical assistance under the  
4           State plan and enrolled with such entity;  
5           or

6           “(II) referral to other health care pro-  
7           viders for such treatment; and

8           “(ii) other information, as determined  
9           by the Secretary or the State; and

10          “(C) such entity complies with such other  
11          requirements relating to access to care as the  
12          Secretary or the State may impose.

13          “(3) CONTRACT WITH STATE AGENCY.—A risk  
14          contracting entity meets the requirements of this  
15          section only if such entity has a written contract  
16          with the State agency which provides—

17               “(A) that the entity will comply with all  
18               applicable provisions of this section, that the  
19               State has the right to penalize the entity for  
20               failure to comply with such requirements and to  
21               terminate the contract in accordance with sub-  
22               section (i), and that the entity will be subject  
23               to penalties imposed by the Secretary under  
24               subsection (h) for failure to comply with such  
25               requirements;

1 “(B) for a payment methodology based on  
2 experience rating or another actuarially sound  
3 methodology approved by the Secretary, which  
4 guarantees (as demonstrated by such models or  
5 formulas as the Secretary may approve) that—

6 “(i) payments to the entity under the  
7 contract shall not exceed an amount equal  
8 to 100 percent of the costs (which shall in-  
9 clude administrative costs and which may  
10 include costs for inpatient hospital services  
11 that would have been incurred in the ab-  
12 sence of such contract) that would have  
13 been incurred by the State agency in the  
14 absence of the contract; and

15 “(ii) the financial risk for inpatient  
16 hospital services is limited to an extent es-  
17 tablished by the State;

18 “(C) that the Secretary and the State (or  
19 any person or organization designated by ei-  
20 ther) shall have the right to audit and inspect  
21 any books and records of the entity (and of any  
22 subcontractor) that pertain—

23 “(i) to the ability of the entity (or a  
24 subcontractor) to bear the risk of potential  
25 financial losses; or



1           “(ii) to services performed or deter-  
2           minations of amounts payable under the  
3           contract;

4           “(D) that in the entity’s enrollment,  
5           reenrollment, or disenrollment of individuals eli-  
6           gible for medical assistance under the State  
7           plan and eligible to enroll, reenroll, or disenroll  
8           with the entity pursuant to the contract, the en-  
9           tity will not discriminate among such individ-  
10          uals on the basis of such individuals’ health sta-  
11          tus or requirements for health care services;

12          “(E)(i) individuals eligible for medical as-  
13          sistance under the State plan who have enrolled  
14          with the entity are permitted to terminate such  
15          enrollment without cause as of the beginning of  
16          the first calendar month (or in the case of an  
17          entity described in subsection (e)(4), as of the  
18          beginning of the first enrollment period) follow-  
19          ing a full calendar month after a request is  
20          made for such termination;

21          “(ii) that when an individual has relocated  
22          outside the entity’s service area, and the entity  
23          has been notified of the relocation, services  
24          (within reasonable limits) furnished by a health  
25          care provider outside the service area will be re-

1           imbursed either by the entity or by the State  
2           agency; and

3           “(iii) for written notification of each such  
4           individual’s right to terminate enrollment,  
5           which shall be provided at the time of such indi-  
6           vidual’s enrollment;

7           “(F) in the case of services immediately re-  
8           quired to treat an unforeseen illness, injury, or  
9           condition, of an individual eligible for medical  
10          assistance under the State plan and enrolled  
11          with the entity—

12                  “(i) that such services shall not be  
13                  subject to a preapproval requirement; and

14                  “(ii) where such services are furnished  
15                  by a health care provider other than the  
16                  entity, for reimbursement of such provider  
17                  either by the entity or by the State agency;

18           “(G) for disclosure of information in ac-  
19           cordance with subsection (g) and section 1124;

20           “(H) that any physician incentive plan op-  
21           erated by the entity meets the requirements of  
22           section 1876(i)(8);

23           “(I) for maintenance of sufficient patient  
24           encounter data to identify the physician who de-  
25           livers services to patients;

1           “(J) that the entity will comply with the  
2           requirement of section 1902(w) with respect to  
3           each enrollee;

4           “(K) that the entity will implement a  
5           grievance system, inform enrollees in writing  
6           about how to use such grievance system, ensure  
7           that grievances are addressed in a timely man-  
8           ner, and report grievances to the State at inter-  
9           vals to be determined by the State;

10          “(L) that contracts between the entity and  
11          each subcontractor of such entity will require  
12          each subcontractor—

13               “(i) to cooperate with the entity in the  
14               implementation of its internal quality as-  
15               surance program under paragraph (4) and  
16               adhere to the standards set forth in the  
17               quality assurance program, including  
18               standards with respect to access to care,  
19               facilities in which patients receive care,  
20               and availability, maintenance, and review  
21               of medical records;

22               “(ii) to cooperate with the Secretary,  
23               the State agency and any contractor to the  
24               State in monitoring and evaluating the  
25               quality and appropriateness of care pro-

1           vided to enrollees as required by Federal or  
2           State laws and regulations; and

3           “(iii) where applicable, to adhere to  
4           regulations and program guidance with re-  
5           spect to reporting requirements under sec-  
6           tion 1905(r);

7           “(M) that, where the State deems it nec-  
8           essary to ensure the timely provision to enroll-  
9           ees of the services listed in subsection  
10          (f)(2)(C)(ii), the State may arrange for the pro-  
11          vision of such services by health care providers  
12          other than the entity and may adjust its pay-  
13          ments to the entity accordingly;

14          “(N) that the entity and the State will  
15          comply with guidelines and regulations issued  
16          by the Secretary with respect to procedures for  
17          marketing and information that must be pro-  
18          vided to individuals eligible for medical assist-  
19          ance under the State plan;

20          “(O) that the entity shall report to the  
21          State, at such time and in such manner as the  
22          State shall require, on the rates paid for hos-  
23          pital services (by type of hospital and type of  
24          service) furnished to individuals enrolled with  
25          the entity;

1           “(P) detailed information regarding the  
2           relative responsibilities of the entity and the  
3           State, for providing (or arranging for the provi-  
4           sion of), and making payment for, the following  
5           items and services:

6                   “(i) immunizations;

7                   “(ii) the purchase of vaccines;

8                   “(iii) lead screening and treatment  
9           services;

10                  “(iv) screening and treatment for tu-  
11           berculosis;

12                  “(v) screening and treatment for, and  
13           preventive services related to, sexually  
14           transmitted diseases, including HIV infec-  
15           tion;

16                  “(vi) screening, diagnostic, and treat-  
17           ment services required under section  
18           1905(r);

19                  “(vii) family planning services;

20                  “(viii) services prescribed under—

21                   “(I) an Individual Education  
22           Plan or Individualized Family Service  
23           Plan under part B or part H of the  
24           Individuals with Disabilities Edu-  
25           cation Act; and

1                   “(II) any other individual plan of  
2                   care or treatment developed under  
3                   this title or title V;

4                   “(ix) transportation needed to obtain  
5                   services to which the enrollee is entitled  
6                   under the State plan or pursuant to an in-  
7                   dividual plan of care or treatment de-  
8                   scribed in subclauses (I) and (II) of clause  
9                   (viii); and

10                  “(x) such other services as the Sec-  
11                  retary may specify;

12                  “(Q) detailed information regarding the  
13                  procedures for coordinating the relative respon-  
14                  sibilities of the entity and the State to ensure  
15                  prompt delivery of, compliance with any appli-  
16                  cable reporting requirements related to, and ap-  
17                  propriate recordkeeping with respect to, the  
18                  items and services described in subparagraph  
19                  (P); and

20                  “(R) such other provisions as the Sec-  
21                  retary may require.

22                  “(4) INTERNAL QUALITY ASSURANCE.—A risk  
23                  contracting entity meets the requirements of this  
24                  section only if such entity has in effect a written in-  
25                  ternal quality assurance program which includes a

1 systematic process to achieve specified and measur-  
2 able goals and objectives for access to, and quality  
3 of, care, which—

4 “(A) identifies the organizational units re-  
5 sponsible for performing specific quality assur-  
6 ance functions, and ensures that such units are  
7 accountable to the governing body of the entity  
8 and that such units have adequate supervision,  
9 staff, and other necessary resources to perform  
10 these functions effectively,

11 “(B) if any quality assurance functions are  
12 delegated to other entities, ensures that the risk  
13 contracting entity remains accountable for all  
14 quality assurance functions and has mecha-  
15 nisms to ensure that all quality assurance ac-  
16 tivities are carried out,

17 “(C) includes methods to ensure that phy-  
18 sicians and other health care professionals  
19 under contract with the entity are licensed or  
20 certified as required by State law, or are other-  
21 wise qualified to perform the services such phy-  
22 sicians and other professionals provide, and  
23 that these qualifications are ensured through  
24 appropriate credentialing and recredentialing  
25 procedures,

1           “(D) provides for continuous monitoring of  
2           the delivery of health care, through—

3                   “(i) identification of clinical areas to  
4                   be monitored, including immunizations,  
5                   prenatal care, services required under sec-  
6                   tion 1905(r), and other appropriate clinical  
7                   areas, to reflect care provided to enrollees  
8                   eligible for medical assistance under the  
9                   State plan,

10                   “(ii) use of quality indicators and  
11                   standards for assessing the quality and ap-  
12                   propriateness of care delivered, and the  
13                   availability and accessibility of all services  
14                   for which the entity is responsible under  
15                   such entity’s contract with the State,

16                   “(iii) use of epidemiological data or  
17                   chart review, as appropriate, and patterns  
18                   of care overall,

19                   “(iv) patient surveys, spot checks, or  
20                   other appropriate methods to determine  
21                   whether—

22                           “(I) enrollees are able to obtain  
23                           timely appointments with primary  
24                           care providers and specialists, and



1                   “(II) enrollees are otherwise  
2                   guaranteed access and care as pro-  
3                   vided under paragraph (2),

4                   “(v) provision of written information  
5                   to health care providers and other person-  
6                   nel on the outcomes, quality, availability,  
7                   accessibility, and appropriateness of care,  
8                   and

9                   “(vi) implementation of corrective ac-  
10                  tions,

11                  “(E) includes standards for timely enrollee  
12                  access to information and care which at a mini-  
13                  mum shall incorporate standards used by the  
14                  State or professional or accreditation bodies for  
15                  facilities furnishing perinatal and neonatology  
16                  care and other forms of specialized medical and  
17                  surgical care,

18                  “(F) includes standards for the facilities in  
19                  which patients receive care,

20                  “(G) includes standards for managing and  
21                  treating medical conditions prevalent among  
22                  such entity’s enrollees eligible for medical as-  
23                  sistance under the State plan,

24                  “(H) includes mechanisms to ensure that  
25                  enrollees eligible for medical assistance under

1 the State plan receive services for which the en-  
2 tity is responsible under the contract which are  
3 consistent with standards established by the ap-  
4 plicable professional societies or government  
5 agencies,

6 “(I) includes standards for the availability,  
7 maintenance, and review of medical records  
8 consistent with generally accepted medical prac-  
9 tice,

10 “(J) provides for dissemination of quality  
11 assurance procedures to health care providers  
12 under contract with the entity, and

13 “(K) meets any other requirements pre-  
14 scribed by the Secretary or the State.

15 “(c) GENERAL REQUIREMENTS FOR PRIMARY CARE  
16 CASE MANAGEMENT PROGRAMS.—A primary care case  
17 management program implemented by a State under this  
18 section shall—

19 “(1) provide that each primary care case man-  
20 agement entity participating in such program has a  
21 written contract with the State agency,

22 “(2) include methods for selection and monitor-  
23 ing of participating primary care case management  
24 entities to ensure—

1           “(A) that the geographic locations, hours  
2           of operation, patient to staff ratio, and other  
3           relevant characteristics of such entities are suf-  
4           ficient to afford individuals eligible for medical  
5           assistance under the State plan access to such  
6           entities that is at least equivalent to the access  
7           to health care providers that would be available  
8           to such individuals if such individuals were not  
9           enrolled with such entity,

10           “(B) that such entities and their profes-  
11           sional personnel are licensed as required by  
12           State law and qualified to provide case manage-  
13           ment services, through methods such as ongo-  
14           ing monitoring of compliance with applicable re-  
15           quirements and providing information and tech-  
16           nical assistance, and

17           “(C) that such entities—

18                   “(i) provide timely and appropriate  
19                   primary care to such enrollees consistent  
20                   with standards established by applicable  
21                   professional societies or governmental  
22                   agencies, or such other standards pre-  
23                   scribed by the Secretary or the State, and

24                   “(ii) where other items and services  
25                   are determined to be medically necessary,

1           give timely approval of such items and  
2           services and referral to appropriate health  
3           care providers,

4           “(3) provide that no preapproval shall be re-  
5           quired for emergency health care items or services,  
6           and

7           “(4) permit individuals eligible for medical as-  
8           sistance under the State plan who have enrolled with  
9           a primary care case management entity to terminate  
10          such enrollment without cause not later than the be-  
11          ginning of the first calendar month following a full  
12          calendar month after the request is made for such  
13          termination.

14          “(d) EXEMPTIONS FROM STATE PLAN REQUIRE-  
15          MENTS.—A State plan may permit or require an individ-  
16          ual eligible for medical assistance under such plan to en-  
17          roll with a risk contracting entity or a primary care case  
18          management entity without regard to the requirements set  
19          forth in the following paragraphs of section 1902(a):

20               “(1) Paragraph (1) (concerning statewideness).

21               “(2) Paragraph (10)(B) (concerning com-  
22          parability of benefits), to the extent benefits not in-  
23          cluded in the State plan are provided.

24               “(3) Paragraph (23) (concerning freedom of  
25          choice of provider), except with respect to services

1 described in section 1905(a)(4)(C) and except as re-  
2 quired under subsection (e).

3 “(e) STATE OPTIONS WITH RESPECT TO ENROLL-  
4 MENT AND DISENROLLMENT.—

5 “(1) MANDATORY ENROLLMENT.—A State plan  
6 may require an individual eligible for medical assist-  
7 ance under such plan to enroll with a risk contract-  
8 ing entity or a primary care case management entity  
9 only if the individual is permitted a choice within a  
10 reasonable service area (as defined by the State)—

11 “(A) between or among 2 or more risk  
12 contracting entities,

13 “(B) among a risk contracting entity and  
14 a primary care case management program, or

15 “(C) among primary care case manage-  
16 ment entities.

17 “(2) REENROLLMENT OF INDIVIDUALS WHO  
18 REGAIN ELIGIBILITY.—In the case of an individual  
19 who—

20 “(A) in a month is eligible for medical as-  
21 sistance under the State plan and enrolled with  
22 a risk contracting entity with a contract under  
23 this section,

24 “(B) in the next month (or next 2 months)  
25 is not eligible for such medical assistance, but

1           “(C) in the succeeding month is again eli-  
2           gible for such benefits,  
3           the State agency (subject to subsection (b)(3)(E))  
4           may enroll the individual for that succeeding month  
5           with such entity, if the entity continues to have a  
6           contract with the State agency under this sub-  
7           section.

8           “(3) DISENROLLMENT.—

9           “(A) RESTRICTIONS ON DISENROLLMENT  
10          WITHOUT CAUSE.—Except as provided in sub-  
11          paragraph (C), a State plan may restrict the  
12          period in which individuals enrolled with risk  
13          contracting entities described in paragraph (4)  
14          may terminate such enrollment without cause to  
15          the first month of each period of enrollment (as  
16          defined in subparagraph (B)), but only if the  
17          State provides notification, at least once during  
18          each such enrollment period, to individuals en-  
19          rolled with such entity of the right to terminate  
20          such enrollment and the restriction on the exer-  
21          cise of this right. Such restriction shall not  
22          apply to requests for termination of enrollment  
23          for cause.

1           “(B) PERIOD OF ENROLLMENT.—For pur-  
2           poses of this paragraph, the term ‘period of en-  
3           rollment’ means—

4                   “(i) a period not to exceed 6 months  
5                   in duration, or

6                   “(ii) a period not to exceed 1 year in  
7                   duration, in the case of a State that, on  
8                   the effective date of this paragraph, had in  
9                   effect a waiver under section 1115 of re-  
10                  quirements under this title under which  
11                  the State could establish a 1-year mini-  
12                  mum period of enrollment with risk con-  
13                  tracting entities.

14           “(4) ENTITIES ELIGIBLE FOR DISENROLLMENT  
15           RESTRICTIONS.—A risk contracting entity described  
16           in this paragraph is—

17                   “(A) a qualified health maintenance orga-  
18                   nization as defined in section 1310(d) of the  
19                   Public Health Service Act,

20                   “(B) an eligible organization with a con-  
21                   tract under section 1876,

22                   “(C) an entity that is receiving (and has  
23                   received during the previous 2 years) a grant of  
24                   at least \$100,000 under section 329(d)(1)(A)  
25                   or 330(d)(1) of the Public Health Service Act,

1 “(D) an entity that—

2 “(i) received a grant of at least  
3 \$100,000 under section 329(d)(1)(A) or  
4 section 330(d)(1) of the Public Health  
5 Service Act in the fiscal year ending June  
6 30, 1976, and has been a grantee under ei-  
7 ther such section for all periods after that  
8 date, and

9 “(ii) provides to its enrollees, on a  
10 prepaid capitation or other risk basis, all  
11 of the services described in paragraphs (1),  
12 (2), (3), (4)(C), and (5) of section 1905(a)  
13 (and the services described in section  
14 1905(a)(7), to the extent required by sec-  
15 tion 1902(a)(10)(D)),

16 “(E) an entity that is receiving (and has  
17 received during the previous 2 years) at least  
18 \$100,000 (by grant, subgrant, or subcontract)  
19 under the Appalachian Regional Development  
20 Act of 1965,

21 “(F) a nonprofit primary health care en-  
22 tity located in a rural area (as defined by the  
23 Appalachian Regional Commission)—

24 “(i) which received in the fiscal year  
25 ending June 30, 1976, at least \$100,000



1 (by grant, subgrant, or subcontract) under  
2 the Appalachian Regional Development Act  
3 of 1965, and

4 “(ii) which, for all periods after such  
5 date, either has been the recipient of a  
6 grant, subgrant, or subcontract under such  
7 Act or has provided services on a prepaid  
8 capitation or other risk basis under a con-  
9 tract with the State agency initially en-  
10 tered into during a year in which the entity  
11 was the recipient of such a grant,  
12 subgrant, or subcontract,

13 “(G) an entity that had contracted with  
14 the State agency prior to 1970 for the provi-  
15 sion, on a prepaid risk basis, of services (which  
16 did not include inpatient hospital services) to  
17 individuals eligible for medical assistance under  
18 the State plan,

19 “(H) a program pursuant to an undertak-  
20 ing described in subsection (l)(3) in which at  
21 least 25 percent of the membership enrolled on  
22 a prepaid basis are individuals who—

23 “(i) are not insured for benefits under  
24 part B of title XVIII or eligible for medical  
25 assistance under the State plan, and

1           “(ii) (in the case of such individuals  
2           whose prepayments are made in whole or  
3           in part by any government entity) had the  
4           opportunity at the time of enrollment in  
5           the program to elect other coverage of  
6           health care costs that would have been  
7           paid in whole or in part by any govern-  
8           mental entity,

9           “(I) an entity that, on the date of enact-  
10          ment of this provision, had a contract with the  
11          State agency under a waiver under section 1115  
12          or 1915(b) and was not subject to a require-  
13          ment under this title to permit disenrollment  
14          without cause, or

15          “(J) an entity that has a contract with the  
16          State agency under a waiver under section  
17          1915(b)(5).

18          “(f) STATE MONITORING AND EXTERNAL REVIEW.—

19               “(1) STATE GRIEVANCE PROCEDURE.—A State  
20          contracting with a risk contracting entity or a pri-  
21          mary care case management entity under this sec-  
22          tion shall provide for a grievance procedure for en-  
23          rollees of such entity with at least the following ele-  
24          ments:

1           “(A) a toll-free telephone number for en-  
2           rollee questions and grievances,

3           “(B) periodic notification of enrollees of  
4           their rights with respect to such entity or pro-  
5           gram,

6           “(C) periodic sample reviews of grievances  
7           registered with such entity or program or with  
8           the State, and

9           “(D) periodic survey and analysis of en-  
10          rollee satisfaction with such entity or program,  
11          including interviews with individuals who  
12          disenroll from the entity or program.

13          “(2) STATE MONITORING OF QUALITY AND AC-  
14          CESS.—

15               “(A) RISK CONTRACTING ENTITIES.—A  
16          State contracting with a risk contracting entity  
17          under this section shall provide for ongoing  
18          monitoring of such entity’s compliance with the  
19          requirements of subsection (b), including com-  
20          pliance with the requirements of such entity’s  
21          contract under subsection (b)(3), and shall un-  
22          dertake appropriate followup activities to ensure  
23          that any problems identified are rectified and  
24          that compliance with the requirements of sub-

1 section (b) and the requirements of the contract  
2 under subsection (b)(3) is maintained.

3 “(B) PRIMARY CARE CASE MANAGEMENT  
4 ENTITIES.—A State electing to implement a  
5 primary care case management program shall  
6 provide for ongoing monitoring of the pro-  
7 gram’s compliance with the requirements of  
8 subsection (c) and shall undertake appropriate  
9 followup activities to ensure that any problems  
10 identified are rectified and that compliance with  
11 subsection (c) is maintained.

12 “(C) SERVICES.—

13 “(i) IN GENERAL.—The State shall  
14 establish procedures (in addition to those  
15 required under subparagraphs (A) and  
16 (B)) to ensure that the services listed in  
17 clause (ii) are available in a timely manner  
18 to an individual enrolled with a risk con-  
19 tracting entity or a primary care case man-  
20 agement entity. Where necessary to ensure  
21 the timely provision of such services, the  
22 State shall arrange for the provision of  
23 such services by health care providers  
24 other than the risk contracting entity or

1 the primary care case management entity  
2 in which an individual is enrolled.

3 “(ii) SERVICES LISTED.—The services  
4 listed in this clause are:

5 “(I) prenatal care;

6 “(II) immunizations;

7 “(III) lead screening and treat-  
8 ment;

9 “(IV) prevention, diagnosis and  
10 treatment of tuberculosis, sexually  
11 transmitted diseases (including HIV  
12 infection), and other communicable  
13 diseases; and

14 “(V) such other services as the  
15 Secretary may specify.

16 “(iii) REPORT.—The procedures re-  
17 ferred to in clause (i) shall be described in  
18 an annual report to the Secretary provided  
19 by the State.

20 “(3) EXTERNAL INDEPENDENT REVIEW.—

21 “(A) IN GENERAL.—Except as provided in  
22 paragraph (4), a State contracting with a risk  
23 contracting entity under this section shall pro-  
24 vide for an annual external independent review  
25 of the quality and timeliness of, and access to,

1 the items and services specified in such entity's  
2 contract with the State agency. Such review  
3 shall be conducted by a utilization control and  
4 peer review organization with a contract under  
5 section 1153 or another organization unaffili-  
6 ated with the State government or with any  
7 risk contracting entity and approved by the  
8 Secretary.

9 “(B) CONTENTS OF REVIEW.—An external  
10 independent review conducted under this para-  
11 graph shall include the following:

12 “(i) a review of the entity's medical  
13 care, through sampling of medical records  
14 or other appropriate methods, for indica-  
15 tions of quality of care and inappropriate  
16 utilization (including overutilization) and  
17 treatment,

18 “(ii) a review of enrollee inpatient and  
19 ambulatory data, through sampling of  
20 medical records or other appropriate meth-  
21 ods, to determine trends in quality and ap-  
22 propriateness of care,

23 “(iii) notification of the entity and the  
24 State when the review under this para-  
25 graph indicates inappropriate care, treat-

1           ment, or utilization of services (including  
2           overutilization), and

3           “(iv) other activities as prescribed by  
4           the Secretary or the State.

5           “(C) AVAILABILITY.—The results of each  
6           external independent review conducted under  
7           this paragraph shall be available to the public  
8           consistent with the requirements for disclosure  
9           of information contained in section 1160.

10          “(4) DEEMED COMPLIANCE WITH EXTERNAL  
11          INDEPENDENT QUALITY OF CARE REVIEW REQUIRE-  
12          MENTS.—

13           “(A) IN GENERAL.—The Secretary may  
14           deem the State to have fulfilled the requirement  
15           for independent external review of quality of  
16           care with respect to an entity which has been  
17           accredited by an organization described in sub-  
18           paragraph (B) and approved by the Secretary.

19           “(B) ACCREDITING ORGANIZATION.—An  
20           accrediting organization described in this sub-  
21           paragraph must—

22           “(i) exist for the primary purpose of  
23           accrediting coordinated care organizations;

24           “(ii) be governed by a group of indi-  
25           viduals representing health care providers,

1 purchasers, regulators, and consumers (a  
2 minority of which shall be representatives  
3 of health care providers);

4 “(iii) have substantial experience in  
5 accrediting coordinated care organizations,  
6 including an organization’s internal quality  
7 assurance program;

8 “(iv) be independent of health care  
9 providers or associations of health care  
10 providers;

11 “(v) be a nonprofit organization; and

12 “(vi) have an accreditation process  
13 which meets requirements specified by the  
14 Secretary.

15 “(5) FEDERAL MONITORING RESPONSIBIL-  
16 ITIES.—The Secretary shall review the external inde-  
17 pendent reviews conducted pursuant to paragraph  
18 (3) and shall monitor the effectiveness of the State’s  
19 monitoring and followup activities required under  
20 subparagraph (A) of paragraph (2). If the Secretary  
21 determines that a State’s monitoring and followup  
22 activities are not adequate to ensure that the re-  
23 quirements of paragraph (2) are met, the Secretary  
24 shall undertake appropriate followup activities to en-



1       sure that the State improves its monitoring and fol-  
2       lowup activities.

3       “(g) TRANSACTIONS WITH PARTIES IN INTEREST.—

4               “(1) IN GENERAL.—Each risk contracting en-  
5       tity which is not a qualified health maintenance or-  
6       ganization (as defined in section 1310(d) of the  
7       Public Health Service Act) must report to the State  
8       and, upon request, to the Secretary, the Inspector  
9       General of the Department of Health and Human  
10      Services, and the Comptroller General of the United  
11      States a description of transactions between the en-  
12      tity and a party in interest (as defined in section  
13      1318(b) of such Act), including the following trans-  
14      actions:

15               “(A) Any sale or exchange, or leasing of  
16      any property between the entity and such a  
17      party.

18               “(B) Any furnishing for consideration of  
19      goods, services (including management serv-  
20      ices), or facilities between the entity and such  
21      a party, but not including salaries paid to em-  
22      ployees for services provided in the normal  
23      course of their employment.

1           “(C) Any lending of money or other exten-  
2           sion of credit between the entity and such a  
3           party.

4           The State or the Secretary may require that infor-  
5           mation reported with respect to a risk contracting  
6           entity which controls, or is controlled by, or is under  
7           common control with, another entity be in the form  
8           of a consolidated financial statement for the risk  
9           contracting entity and such entity.

10          “(2) AVAILABILITY OF INFORMATION.—Each  
11          risk contracting entity shall make the information  
12          reported pursuant to paragraph (1) available to its  
13          enrollees upon reasonable request.

14          “(h) REMEDIES FOR FAILURE TO COMPLY.—

15          “(1) IN GENERAL.—If the Secretary determines  
16          that a risk contracting entity or a primary care case  
17          management entity—

18               “(A) fails substantially to provide services  
19               required under section 1905(r), when such an  
20               entity is required to do so, or provide medically  
21               necessary items and services that are required  
22               to be provided to an individual enrolled with  
23               such an entity, if the failure has adversely af-  
24               fected (or has substantial likelihood of adversely  
25               affecting) the individual;

1           “(B) imposes premiums on individuals en-  
2           rolled with such an entity in excess of the pre-  
3           miums permitted under this title;

4           “(C) acts to discriminate among individ-  
5           uals in violation of the provision of subsection  
6           (b)(3)(D), including expulsion or refusal to  
7           reenroll an individual or engaging in any prac-  
8           tice that would reasonably be expected to have  
9           the effect of denying or discouraging enrollment  
10          (except as permitted by this section) by eligible  
11          individuals with the entity whose medical condi-  
12          tion or history indicates a need for substantial  
13          future medical services;

14          “(D) misrepresents or falsifies information  
15          that is furnished—

16                 “(i) to the Secretary or the State  
17                 under this section; or

18                 “(ii) to an individual or to any other  
19                 entity under this section; or

20          “(E) fails to comply with the requirements  
21          of section 1876(i)(8),

22          the Secretary may provide, in addition to any other  
23          remedies available under law, for any of the rem-  
24          edies described in paragraph (2).

1           “(2) ADDITIONAL REMEDIES.—The remedies  
2 described in this paragraph are—

3           “(A) civil money penalties of not more  
4 than \$25,000 for each determination under  
5 paragraph (1), or, with respect to a determina-  
6 tion under subparagraph (C) or (D)(i) of such  
7 paragraph, of not more than \$100,000 for each  
8 such determination, plus, with respect to a de-  
9 termination under paragraph (1)(B), double the  
10 excess amount charged in violation of such  
11 paragraph (and the excess amount charged  
12 shall be deducted from the penalty and returned  
13 to the individual concerned), and plus, with re-  
14 spect to a determination under paragraph  
15 (1)(C), \$15,000 for each individual not enrolled  
16 as a result of a practice described in such para-  
17 graph, or

18           “(B) denial of payment to the State for  
19 medical assistance furnished by a risk contract-  
20 ing entity or a primary care case management  
21 entity under this section for individuals enrolled  
22 after the date the Secretary notifies the entity  
23 of a determination under paragraph (1) and  
24 until the Secretary is satisfied that the basis for

1           such determination has been corrected and is  
2           not likely to recur.

3       The provisions of section 1128A (other than sub-  
4       sections (a) and (b)) shall apply to a civil money  
5       penalty under subparagraph (A) in the same manner  
6       as such provisions apply to a penalty or proceeding  
7       under section 1128A(a).

8       “(i) TERMINATION OF CONTRACT BY STATE.—Any  
9       State which has a contract with a risk contracting entity  
10      or a primary care case management entity may terminate  
11      such contract if such entity fails to comply with the terms  
12      of such contract or any applicable provision of this section.

13      “(j) FAIR HEARING.—Nothing in this section shall  
14      affect the rights of an individual eligible to receive medical  
15      assistance under the State plan to obtain a fair hearing  
16      under section 1902(a)(3) or under applicable State law.

17      “(k) REFERRAL PAYMENTS.—For 1 year following  
18      the date on which individuals eligible for medical assist-  
19      ance under the State plan in a service area are required  
20      to enroll with a risk contracting entity or a primary care  
21      case management entity, Federally qualified health cen-  
22      ters and rural health centers located in such service area  
23      or providing care to such enrollees, shall receive a fee for  
24      educating such enrollees about the availability of services

1 from the risk contracting entity or primary care case man-  
2 agement entity with which such enrollees are enrolled.

3 “(l) SPECIAL RULES.—

4 “(1) NONAPPLICABILITY OF CERTAIN PROVI-  
5 SIONS TO CERTAIN RISK CONTRACTING ENTITIES.—

6 In the case of any risk contracting entity which—

7 “(A)(i) is an individual physician or a phy-  
8 sician group practice of less than 50 physicians,  
9 and

10 “(ii) is not described in paragraphs (A)  
11 and (B) of subsection (b)(1), and

12 “(B) is at risk only for the health care  
13 items and services directly provided by such en-  
14 tity,

15 paragraphs (3)(K), (3)(L), (3)(O), (3)(P), and (4)  
16 of subsection (b), and paragraph (3) of subsection  
17 (f), shall not apply to such entity.

18 “(2) EXCEPTION FROM DEFINITION OF RISK  
19 CONTRACTING ENTITY.—For purposes of this sec-  
20 tion, the term ‘risk contracting entity’ shall not in-  
21 clude a health insuring organization which was used  
22 by a State before April 1, 1986, to administer a por-  
23 tion of the State plan of such State on a statewide  
24 basis.

1           “(3) NEW JERSEY.—The rules under section  
2           1903(m)(6) as in effect on the day before the effec-  
3           tive date of this section shall apply in the case of an  
4           undertaking by the State of New Jersey (as de-  
5           scribed in such section 1903(m)(6)).

6           “(m) CONTINUATION OF CERTAIN COORDINATED  
7 CARE PROGRAMS.—The Secretary may provide for the  
8 continuation of any coordinated care program operating  
9 under section 1115 or 1915 without requiring compliance  
10 with any provision of this section which conflicts with the  
11 continuation of such program and without requiring any  
12 additional waivers under such sections 1115 and 1915 if  
13 the program has been successful in assuring quality and  
14 containing costs (as determined by the Secretary) and is  
15 likely to continue to be successful in the future.

16          “(n) GUIDELINES AND MODEL CONTRACT.—

17               “(1) GUIDELINES ON SOLVENCY.—At the earli-  
18               est practicable time after the date of enactment of  
19               this section, the Secretary shall issue guidelines con-  
20               cerning solvency standards for risk contracting enti-  
21               ties and subcontractors of such risk contracting enti-  
22               ties. Such guidelines shall take into account charac-  
23               teristics that may differ among risk contracting enti-  
24               ties including whether such an entity is at risk for  
25               inpatient hospital services.

1           “(2) GUIDELINES ON MARKETING.—At the ear-  
2           liest practicable time after the date of enactment of  
3           this section, the Secretary shall issue guidelines con-  
4           cerning—

5                   “(A) marketing undertaken by any risk  
6                   contracting entity or any primary care case  
7                   management program to individuals eligible for  
8                   medical assistance under the State plan, and

9                   “(B) information that must be provided by  
10                  States or any such entity to individuals eligible  
11                  for medical assistance under the State plan  
12                  with respect to—

13                          “(i) the options and rights of such in-  
14                          dividuals to enroll with, and disenroll from,  
15                          any such entity, as provided in this section,  
16                          and

17                          “(ii) the availability of services from  
18                          any such entity (including a list of services  
19                          for which such entity is responsible or  
20                          must approve and information on how to  
21                          obtain services for which such entity is not  
22                          responsible).

23           In developing the guidelines under this paragraph,  
24           the Secretary shall address the special circumstances  
25           of children with special health care needs (as defined



1 in subsection (e)(1)(B)(ii)) and other individuals  
2 with special health care needs.

3 “(3) MODEL CONTRACT.—The Secretary shall  
4 develop a model contract to reflect the requirements  
5 of subsection (b)(3) and such other requirements as  
6 the Secretary determines appropriate.”

7 (b) WAIVERS FROM REQUIREMENTS ON COORDI-  
8 NATED CARE PROGRAMS.—Section 1915(b) (42 U.S.C.  
9 1396n) is amended—

10 (1) in the matter preceding paragraph (1), by  
11 striking “as may be necessary” and inserting “, and  
12 section 1931 as may be necessary”;

13 (2) in paragraph (1), by striking “a primary  
14 care case management system or”;

15 (3) by striking “and” at the end of paragraph  
16 (3);

17 (4) by striking the period at the end of para-  
18 graph (4) and inserting “, and”; and

19 (5) by inserting after paragraph (4) the follow-  
20 ing new paragraph:

21 “(5) to permit a risk contracting entity (as de-  
22 fined in section 1931(a)(3)) to restrict the period in  
23 which individuals enrolled with such entity may ter-  
24minate such enrollment without cause in accordance  
25 with section 1931(e)(3)(A).”.

1 (c) STATE OPTION TO GUARANTEE MEDICAID ELIGI-  
2 BILITY.—Section 1902(e)(2) (42 U.S.C. 1396a(e)(2)) is  
3 amended—

4 (1) in subparagraph (A), by striking all that  
5 precedes “(but for this paragraph)” and inserting  
6 “In the case of an individual who is enrolled—

7 “(i) with a qualified health maintenance  
8 organization (as defined in title XIII of the  
9 Public Health Service Act) or with a risk con-  
10 tracting entity (as defined in section  
11 1931(a)(3)), or

12 “(ii) with any risk contracting entity (as  
13 defined in section 1931(a)(3)) in a State that,  
14 on the effective date of this provision, had in ef-  
15 fect a waiver under section 1115 of require-  
16 ments under this title under which the State  
17 could extend eligibility for medical assistance  
18 for enrollees of such entity, or

19 “(iii) with an eligible organization with a  
20 contract under section 1876,  
21 and who would”,

22 (2) in subparagraph (B), by striking “organiza-  
23 tion or” each place it appears, and

24 (3) by adding at the end the following new sub-  
25 paragraph:

1           “(C) The State plan may provide, notwith-  
 2           standing any other provision of this title, that  
 3           an individual shall be deemed to continue to be  
 4           eligible for benefits under this title until the end  
 5           of the month following the month in which such  
 6           individual would (but for this paragraph) lose  
 7           such eligibility because of excess income and re-  
 8           sources, if the individual is enrolled with a risk  
 9           contracting entity or primary care case manage-  
 10          ment entity (as those terms are defined in sec-  
 11          tion 1931(a)).”.

12          (d) ENHANCED MATCH RELATED TO QUALITY RE-  
 13          VIEW.—Section       1903(a)(3)(C)       (42       U.S.C.  
 14          1396b(a)(3)(C)) is amended—

15               (1) by striking “organization or by” and insert-  
 16               ing “organization, by”; and

17               (2) by striking “section 1152, as determined by  
 18               the Secretary,” and inserting “section 1152, as de-  
 19               termined by the Secretary, or by another organiza-  
 20               tion approved by the Secretary which is unaffiliated  
 21               with the State government or with any risk contract-  
 22               ing entity (as defined in section 1931(a)(3)),”.

23          (e) CONFORMING AMENDMENTS.—

24               (1) Section 1128(b)(6)(C)(i) (42 U.S.C. 1320a-  
 25               7(b)(6)(C)(i)) is amended by striking “health main-

1       tenance organization” and inserting “risk contract-  
2       ing entity”.

3           (2)    Section    1902(a)(23)    (42    U.S.C.  
4       1396a(a)(23)) is amended by striking “primary  
5       care-case management system (described in section  
6       1915(b)(1)), a health maintenance organization,”  
7       and inserting “primary care case management pro-  
8       gram (as defined in section 1931(a)(1)), a risk con-  
9       tracting entity (as defined in section 1931(a)(3)),”.

10          (3)    Section    1902(a)(30)(C)   (42    U.S.C.  
11       1396a(a)(30)(C)) is amended by striking “use a uti-  
12       lization” and all that follows through “with the re-  
13       sults” and inserting “provide for independent review  
14       and quality assurance of entities with contracts  
15       under section 1931, in accordance with subsection  
16       (f) of such section 1931, with the results”.

17          (4)    Section    1902(a)(57)    (42    U.S.C.  
18       1396a(a)(57)) is amended by striking “or health  
19       maintenance organization (as defined in section  
20       1903(m)(1)(A))” and inserting “risk contracting en-  
21       tity, or primary care case management entity (as de-  
22       fined in section 1931(a))”.

23          (5)    Section 1902(a) (42 U.S.C. 1396a), as  
24       amended by sections 121, 201(a), 851, 854, and  
25       855, is amended—

1 (A) by striking “and” at the end of para-  
2 graph (66);

3 (B) by striking the period at the end of  
4 paragraph (67) and inserting “; and”; and

5 (C) by adding at the end the following new  
6 paragraphs:

7 “(68) at State option, provide for a primary  
8 care case management program in accordance with  
9 section 1931; and

10 “(69) at State option, provide for a program  
11 under which the State contracts with risk contract-  
12 ing entities in accordance with section 1931.”.

13 (6) Section 1902(p)(2) (42 U.S.C. 1396a(p)(2))  
14 is amended by striking “health maintenance organi-  
15 zation (as defined in section 1903(m))” and insert-  
16 ing “risk contracting entity (as defined in section  
17 1931(a)(3))”.

18 (7) Section 1902(w) (42 U.S.C. 1396a(w)) is  
19 amended—

20 (A) in paragraph (1), by striking “section  
21 1903(m)(1)(A)” and inserting “section  
22 1931(a)(3)”, and

23 (B) in paragraph (2)(E)—

1 (i) by striking “health maintenance  
2 organization” and inserting “risk contract-  
3 ing entity”, and

4 (ii) by striking “organization” and in-  
5 serting “entity”.

6 (8) Section 1903(k) (42 U.S.C. 1396b(k)) is  
7 amended by striking “health maintenance organiza-  
8 tion which meets the requirements of subsection (m)  
9 of this section” and inserting “risk contracting en-  
10 tity which meets the requirements of section 1931”.

11 (9) Section 1903(w)(7)(A)(viii) (42 U.S.C.  
12 1396b(w)(7)(A)(viii)) is amended by striking “health  
13 maintenance organizations (and other organizations  
14 with contracts under section 1903(m))” and insert-  
15 ing “risk contracting entities with contracts under  
16 section 1931”.

17 (10) Section 1905(a) (42 U.S.C. 1396d(a)) is  
18 amended, in the matter preceding clause (i), by in-  
19 serting “(which may be on a prepaid capitation or  
20 other risk basis)” after “payment”.

21 (11) Section 1916(b)(2)(D) (42 U.S.C.  
22 1396o(b)(2)(D)) is amended by striking “health  
23 maintenance organization (as defined in section  
24 1903(m))” and inserting “risk contracting entity (as  
25 defined in section 1931(a)(3))”.

1           (12) Section 1925(b)(4)(D)(iv) (42 U.S.C.  
2   1396r-6(b)(4)(D)(iv)) is amended—

3           (A) in the heading, by striking “**HMO**”  
4           and inserting “**RISK CONTRACTING ENTITY**”,

5           (B) by striking “health maintenance orga-  
6           nization (as defined in section 1903(m)(1)(A))”  
7           and inserting “risk contracting entity (as de-  
8           fined in section 1931(a)(3)”, and

9           (C) by striking “health maintenance orga-  
10          nization in accordance with section 1903(m))”  
11          and inserting “risk contracting entity in accord-  
12          ance with section 1931”.

13          (13) Paragraphs (1) and (2) of section 1926(a)  
14          (42 U.S.C. 1396r-7(a)) are each amended by strik-  
15          ing “health maintenance organizations under section  
16          1903(m))” and inserting “risk contracting entities  
17          under section 1931”.

18          (13) Section 1927(j)(1) is amended by striking  
19          “\* \* \* Health Maintenance Organizations, includ-  
20          ing those organizations that contract under section  
21          1903(m))” and inserting “risk contracting entities  
22          (as defined in section 1931(a)(3))”.

23          (f) EFFECTIVE DATE.—The amendments made by  
24          this section shall become effective with respect to calendar  
25          quarters beginning on or after January 1, 1995.

1       **PART III—LONG-TERM CARE PROVISIONS**

2       **SEC. 871. STATE OPTION TO PROVIDE HOME OR COMMU-**  
3               **NITY BASED CARE SERVICES.**

4       (a) PROVISION AS OPTIONAL SERVICE.—Section  
5       1905(a) (42 U.S.C. 1396d(a)) is amended—

6               (1) by striking “and” at the end of paragraph  
7               (24);

8               (2) by redesignating paragraph (25) as para-  
9               graph (26); and

10              (3) by inserting after paragraph (24) the fol-  
11              lowing new paragraph:

12              “(25) home or community based services (as  
13              defined in section 1905(t)).”.

14       (b) DEFINITION.—Section 1905 (42 U.S.C. 1396d)  
15       is amended by adding at the end the following new sub-  
16       section:

17              “(t) The term ‘home or community based services’  
18       means services (other than room and board) approved by  
19       the Secretary which are provided pursuant to a written  
20       plan of care to individuals who require the level of care  
21       provided in a hospital, nursing facility, or intermediate  
22       care facility for the mentally retarded, the cost of which  
23       could be reimbursed under the State plan. For purposes  
24       of this subsection, the term ‘room and board’ shall not  
25       include an amount established under a method determined  
26       by the State to reflect the portion of costs of rent and



1 food attributable to an unrelated personal caregiver who  
2 is residing in the same household with an individual who,  
3 but for assistance of such caregiver, would require admis-  
4 sion to a hospital, nursing facility, or intermediate care  
5 facility for the mentally retarded.”.

6 (c) CONFORMING AMENDMENTS.—(1) Section  
7 1902(a)(10)(C)(iv) (42 U.S.C. 1396a(a)(10)(C)(iv)) is  
8 amended by striking “through (24)” and inserting  
9 “through (25)”.

10 (2) Section 1902(j) (42 U.S.C. 1396a(j)) is amended  
11 by striking “through (25)” and inserting “through (26)”.

12 **SEC. 872. ELIMINATION OF RULE REGARDING AVAILABIL-**  
13 **ITY OF BEDS IN CERTAIN INSTITUTIONS.**

14 (a) IN GENERAL.—The first sentence of section  
15 1915(c)(1) (42 U.S.C. 1396n(c)(1)) is amended by insert-  
16 ing the following before the end period: “(at the option  
17 of the State, such determination may be made without re-  
18 gard to the availability of beds in such a hospital, nursing  
19 facility, or intermediate care facility for the mentally re-  
20 tarder located in the State)”.

21 (b) EFFECTIVE DATE.—The amendment made by  
22 subsection (a) shall be effective with respect to waivers  
23 granted or renewed on or after January 1, 1995.

1 **SEC. 873. CERTAIN DEMONSTRATION PROJECTS PER-**  
 2 **MITTED UNDER THE MEDICAID PROGRAM.**

3 (a) IN GENERAL.—Section 1917(b) of the Social Se-  
 4 curity Act (42 U.S.C. 1396p(b)) is amended—

5 (1) in paragraph (1), by striking subparagraph  
 6 (C);

7 (2) in paragraph (3), by striking “(other than  
 8 paragraph (1)(C))”; and

9 (3) in paragraph (4)(B), by striking “(and shall  
 10 include, in the case of an individual to whom para-  
 11 graph (1)(C)(i) applies)”.

12 (b) EFFECTIVE DATE.—Section 1917(b) of the So-  
 13 cial Security Act (42 U.S.C. 1396p(b)) shall be applied  
 14 and administered as if the provisions stricken by para-  
 15 graph (1) had not been enacted.

16 **SEC. 874. ELIMINATION OF REQUIREMENT OF PRIOR INSTI-**  
 17 **TUTIONALIZATION WITH RESPECT TO HA-**  
 18 **BILITATION SERVICES FURNISHED UNDER A**  
 19 **WAIVER FOR HOME OR COMMUNITY-BASED**  
 20 **SERVICES.**

21 (a) IN GENERAL.—Section 1915(c)(5) (42 U.S.C.  
 22 1396n(c)(5)) is amended in the matter preceding subpara-  
 23 graph (A) by striking “, with respect to individuals who  
 24 receive such services after discharge from a nursing facil-  
 25 ity or intermediate care facility for the mentally retarded”.

1 (b) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to services furnished on or after  
3 January 1, 1995.

4 **SEC. 875. RELIEF FROM THIRD PARTY LIABILITY REQUIRE-**  
5 **MENTS WHEN COST-EFFECTIVE.**

6 (a) IN GENERAL.—Section 1902(a)(25)(B) (42  
7 U.S.C. 1396a(a)(25)(B)) is amended to read as follows—

8 “(B) that in any case where such a legal liabil-  
9 ity is found to exist after medical assistance has  
10 been made available, the State or local agency will  
11 seek reimbursement for such assistance to the extent  
12 of such legal liability, unless—

13 “(i) the amount of reimbursement the  
14 State can reasonably expect to recover for medi-  
15 cal assistance furnished to an individual does  
16 not exceed the costs of such recovery, or

17 “(ii) with respect to case management  
18 services (as defined in section 1915(g)(2)), the  
19 State demonstrates to the satisfaction of the  
20 Secretary that it is not cost-effective in the ag-  
21 gregate to seek such recovery with respect to  
22 such services furnished to individuals covered  
23 under the State plan, using methods specified  
24 by the Secretary which may include a dem-

1           onstration that such services are not generally  
2           covered by health insurers in the State;”.

3           (b) EFFECTIVE DATE.—The amendments made by  
4 this section shall become effective on January 1, 1995.

5 **SEC. 876. STATE EXPENDITURES FOR MEDICAL ASSIST-**  
6 **ANCE WITH RESPECT TO HOME AND COMMU-**  
7 **NITY-BASED SERVICES PROVIDED UNDER A**  
8 **WAIVER.**

9           (a) IN GENERAL.—Section 1915(d)(5)(B) (42 U.S.C.  
10 1396n(d)(5)(B)) is amended—

11           (1) in clause (i), by striking “times the number  
12 of years” and inserting “compounded annually for  
13 years”;

14           (2) in clause (ii), by striking “times the number  
15 of years” and inserting “compounded annually for  
16 years”; and

17           (3) in clause (iv), by striking “December 22,  
18 1987” and inserting “the date of the enactment of  
19 the Omnibus Budget Reconciliation Act of 1986”.

20           (b) EFFECTIVE DATE.—The amendments made by  
21 subsection (a) shall be effective as if included in the enact-  
22 ment of the Omnibus Budget Reconciliation Act of 1987.

1 **SEC. 877. EXTENSION AND CONSOLIDATION OF FRAIL EL-**  
2 **DERLY DEMONSTRATION PROJECT WAIVERS.**

3 (a) ELIMINATION OF LIMIT ON NUMBER OF WAIV-  
4 ERS.—

5 (1) IN GENERAL.—Section 9412(b)(1) of the  
6 Omnibus Budget Reconciliation Act of 1986 is  
7 amended by striking “not more than 15”.

8 (2) TRANSITION.—The Secretary of Health and  
9 Human Services shall grant waivers under section  
10 9412(b) of the Omnibus Budget Reconciliation Act  
11 of 1986 to not more than—

12 (A) 50 organizations before July 1, 1995,

13 or

14 (B) 75 organizations before July 1, 1996.

15 (b) INDEFINITE EXTENSION OF PARTICIPATION AND  
16 STATUS AS PROVIDERS.—Section 9412(b)(2) of the Om-  
17 nibus Budget Reconciliation Act of 1986 is amended—

18 (1) in subparagraph (A), by striking “subpara-  
19 graph (B)” and inserting “this paragraph”,

20 (2) in subparagraph (A), by adding at the end  
21 the following: “Except as otherwise provided by law  
22 or regulation, such terms and conditions, with re-  
23 spect to an organization, shall be substantially equiv-  
24 alent to the terms and conditions provided under the  
25 Protocol for the Program of All-inclusive Care for  
26 the Elderly (PACE), as published by On Lok, Inc.

1 (and as recognized by the Health Care Financing  
2 Administration) as of June 30, 1994, and made gen-  
3 erally available.”;

4 (2) in subparagraph (C), by striking “may ex-  
5 tend” and inserting “shall extend for an indefinite  
6 period”; and

7 (3) by adding at the end the following:

8 “(D) Upon successful completion of the initial period  
9 of the waiver under this subsection, an organization shall  
10 be afforded regular provider status under titles XVIII and  
11 XIX of the Social Security Act in accordance with appro-  
12 priate regulations to be promulgated by the Secretary.  
13 This subparagraph shall apply to organizations operating  
14 under a waiver on or after July 1, 1997.

15 “(E) The provisions of this paragraph also shall  
16 apply to the organization under the On Lok waiver de-  
17 scribed in subparagraph (A).

18 “(F) Organizations under this paragraph shall ordi-  
19 narily be reimbursed on a capitation basis. The organiza-  
20 tions may provide additional services as may be deemed  
21 appropriate by the organizations without regard to wheth-  
22 er such services are specifically reimbursable through capi-  
23 tation payments.”.

24 (c) TREATMENT OF APPLICATIONS.—Section  
25 9412(b)(1) of such Act is amended by adding at the end

1 the following: “An appropriately completed application for  
2 a waiver under this subsection is deemed approved unless  
3 the Secretary specifically disapproves it in writing within  
4 90 days of the date of its filing (or, if the Secretary re-  
5 quests reasonable and substantial additional information  
6 within such 90 day period, within 90 days of the date of  
7 providing such additional information). The Secretary  
8 shall have sole authority to approve or disapprove the ini-  
9 tial and subsequent eligibility of an organization for a  
10 waiver and shall make such determinations in a timely  
11 manner.”.

12 (d) PROMOTION OF ADDITIONAL APPLICATIONS.—  
13 Section 9412(b) of such Act is amended by adding at the  
14 end the following:

15 “(5) The Secretary shall institute an organized  
16 effort to promote the development of organizations  
17 under this subsection.”.

18 (e) PROVISION OF ADDITIONAL SERVICES.—Section  
19 9412(b) of such Act, as amended by subsection (d), is fur-  
20 ther amended by adding at the end the following:

21 “(6) Nothing in this subsection shall prevent an  
22 organization with a waiver under this subsection  
23 from developing and providing appropriate services  
24 to frail populations that may not be elderly, except  
25 where the Secretary finds that such an extension im-

1 pair the ability of the organization to provide serv-  
2 ices required under the waiver.”.

3 **SEC. 878. CERTAIN IMPROVEMENTS IN MEDICAID CASE**  
4 **MANAGEMENT SERVICES AND HOME AND**  
5 **COMMUNITY-BASED WAIVERS.**

6 (a) IN GENERAL.—Section 1902(a) (42 U.S.C.  
7 1396a) is amended—

8 (1) in paragraph (23), by inserting “(including  
9 case management services under subsections (c), (d),  
10 and (g) of such section)” after “in section 1915”;  
11 and

12 (2) in paragraph (32)—

13 (A) by striking the period at the end of  
14 subparagraph (C) and inserting “; and”; and

15 (B) by adding at the end the following new  
16 subparagraph:

17 “(D) in the case of services arranged  
18 through the case management agency under  
19 subsections (c), (d), or (g) of section 1915, pay-  
20 ments made by the case management agency to  
21 providers of services shall be permitted provided  
22 that—

23 “(i) the case management entity is a  
24 nonprofit entity;



1 “(ii) the case management entity  
 2 maintains a clear system of records dem-  
 3 onstrating conformity between payments  
 4 made and services required under the indi-  
 5 vidual’s plan of care; and

6 “(iii) the entity makes assurances sat-  
 7 isfactory to the State that providers paid  
 8 by the entity, for covered services to indi-  
 9 viduals eligible under this title, are eligible  
 10 for payments under the provisions of this  
 11 title;”.

12 (b) EFFECTIVE DATE.—The amendments made by  
 13 this section shall apply to payments for medical assistance  
 14 for calendar quarters beginning on or after January 1,  
 15 1995.

#### 16 **PART IV—OTHER PROVISIONS**

#### 17 **SEC. 881. AMENDMENTS TO PROVISIONS REQUIRING** 18 **STATES TO MAKE DSH PAYMENT ADJUST-** 19 **MENTS.**

20 (a) IN GENERAL.—

21 (1) ADJUSTMENT TO NATIONAL DSH PAYMENT  
 22 LIMIT.—Section 1923(f)(1)(B) (42 U.S.C. 1396r-  
 23 4(f)(1)(B)) is amended by striking “12 percent” and  
 24 inserting “9 percent”.

1           (2) ADJUSTMENTS TO STATE ALLOTMENT LIM-  
 2       ITS.—Section 1923(f)(2)(B)(i) (42 U.S.C. 1396r-  
 3       4(f)(2)(B)(i)) is amended by striking “12 percent”  
 4       and inserting “9 percent”.

5           (3) ADJUSTMENT RELATING TO HIGH DSH  
 6       STATES.—

7                   (A)           IN           GENERAL.—Section  
 8       1923(f)(2)(B)(i)       (42       U.S.C.       1396r-  
 9       4(f)(2)(B)(i)) is amended by striking “the State  
 10       DSH allotment shall equal the State based al-  
 11       lotment” and inserting “the State DSH allot-  
 12       ment shall be an amount equal to the State  
 13       based allotment less 25 percent of such allot-  
 14       ment”.

15           (4) EFFECTIVE DATE.—The amendments made  
 16       by this section shall be effective for calendar quar-  
 17       ters beginning on or after January 1, 1997.

18       **SEC. 882. RECOMMENDATIONS BY THE SECRETARY ON A**  
 19                               **PHASED-IN ELIMINATION OF MEDICAID HOS-**  
 20                               **PITAL DISPROPORTIONATE SHARE ADJUST-**  
 21                               **MENT PAYMENTS.**

22       Not later than January 1, 2000, the Secretary shall  
 23       submit recommendations to Congress on a phased-in  
 24       elimination of the hospital disproportionate share adjust-

1 ment payments under section 1923 of the Social Security  
2 Act.

3 **SEC. 883. REVISION OF FEDERAL MEDICAL ASSISTANCE**  
4 **PERCENTAGE FOR CERTAIN STATES.**

5 (a) IN GENERAL.—Section 1905(b) (42 U.S.C.  
6 1396d(b)) is amended—

7 (1) by redesignating clauses (1) and (2) as  
8 clauses (2) and (3) and by inserting after “except  
9 that” the following: “(1) for Alaska, the State per-  
10 centage shall be that percentage which bears the  
11 same ratio to 45 per centum as the square of the  
12 adjusted per capita income of such State bears to  
13 the square of the per capita income of the United  
14 States;”; and

15 (2) by inserting after the first sentence the fol-  
16 lowing: “The ‘adjusted per capita income’ for Alaska  
17 shall be determined by dividing the State 3-year av-  
18 erage per capita income by 1.25.”.

19 (b) EFFECTIVE DATE.—The amendments made by  
20 this section shall become effective on October 1, 1995.

21 **SEC. 884. CRITERIA FOR DETERMINING THE AMOUNT OF**  
22 **DISALLOWANCES.**

23 (a) IN GENERAL.—

1 (1) CRITERIA FOR INITIAL DETERMINATIONS.—

2 Section 1903 (42 U.S.C. 1396b) is amended by add-  
3 ing at the end the following new subsection:

4 “(x) If the Secretary determines that a disallowance  
5 of Federal financial participation should be made under  
6 this title with respect to any item or class of items, the  
7 Secretary shall, in making a determination with respect  
8 to the amount of such disallowance, take into account (to  
9 the extent the State makes a showing) factors which shall  
10 include—

11 “(1) whether the amount of the disallowance is  
12 reasonably related to the act or omission by the  
13 State which is the basis for the disallowance; and

14 “(2) whether the act or omission by the State  
15 which is the basis for the disallowance was based on  
16 a reasonable interpretation of Federal statutes, Fed-  
17 eral regulations, or any written guidance provided by  
18 the Secretary.”.

19 (2) CRITERIA FOR REDETERMINATIONS.—Sec-  
20 tion 1116(d) (42 U.S.C. 1316(d)) is amended—

21 (A) by striking “(d)” and inserting  
22 “(d)(1)”; and

23 (B) by adding at the end the following new  
24 paragraph:

1       “(2) In conducting any reconsideration of a disallow-  
 2       ance of Federal financial participation by the Secretary  
 3       under title XIX, the Departmental Appeals Board of the  
 4       Department of Health and Human Services (or another  
 5       entity designated by the Secretary), shall, if such Board  
 6       or entity upholds the basis for the disallowance, determine  
 7       whether the amount of the disallowance properly takes  
 8       into account the factors listed in section 1903(x). If the  
 9       amount of the disallowance does not properly take into  
 10      account such factors, the Board shall adjust such amount  
 11      in accordance with such factors.”.

12      (b) EFFECTIVE DATE.—The amendment made by  
 13      subsection (a) shall apply to disallowances made after the  
 14      date of the enactment of this Act and shall take effect  
 15      without regard to the promulgation of implementing regu-  
 16      lations.

17      **SEC. 885. TECHNICAL CORRECTIONS RELATING TO SEC-**  
 18                                   **TION 4752 OF OBRA-1990 (PHYSICIANS’ SERV-**  
 19                                   **ICES).**

20      (a) Paragraph (59) of section 1902(a) (42 U.S.C.  
 21      1396a(a)), as added by section 4752(c)(1)(C) of the Om-  
 22      nibus Budget Reconciliation Act of 1990 and as redesign-  
 23      ated by section 13623(a)(6) of the Omnibus Budget Rec-  
 24      onciliation Act of 1993, is amended by striking “sub-  
 25      section (v)” and inserting “subsection (x)”.

1       (b) Section 1903(i)(12) (42 U.S.C. 1396b(i)(12)), as  
2 inserted by section 4752(e) of the Omnibus Budget Rec-  
3 onciliation Act of 1990 and as redesignated by section  
4 13631(c)(3) of the Omnibus Budget Reconciliation Act of  
5 1993, is amended—

6           (1) by amending clause (i) of subparagraph (A)  
7 to read as follows:

8                   “(i) is certified in family practice or  
9                   pediatrics by the medical specialty board  
10                  recognized by the American Board of Med-  
11                  ical Specialties for family practice or pedi-  
12                  atrics or is certified in general practice or  
13                  pediatrics by the medical specialty board  
14                  recognized by the American Osteopathic  
15                  Association,”;

16          (2) by amending clause (i) of subparagraph (B)  
17 to read as follows:

18                   “(i) is certified in family practice or  
19                   obstetrics by the medical specialty board  
20                  recognized by the American Board of Med-  
21                  ical Specialties for family practice or ob-  
22                  stetrics or is certified in general practice or  
23                  obstetrics by the Medical Specialty Board  
24                  recognized by the American Osteopathic  
25                  Association,”; and

1 (3) in subparagraphs (A) and (B)—

2 (A) by striking “or” at the end of clause

3 (v);

4 (B) by redesignating clause (vi) as clause

5 (vii); and

6 (C) by inserting after clause (v) the follow-

7 ing new clause:

8 “(vi) delivers such services in the

9 emergency department of a hospital par-

10 ticipating in the State plan approved under

11 this title, or”.

12 **TITLE IX—DEPARTMENT OF**  
13 **VETERANS AFFAIRS**

14 **SEC. 901. SHORT TITLE.**

15 This title may be cited as the “Veterans Health Care

16 Administrative Flexibility Act of 1994”.

17 **SEC. 902. PURPOSE.**

18 The purpose of this title is to facilitate the provision

19 of health care services by the Department of Veterans Af-

20 fairs by—

21 (1) granting the Department sufficient flexibil-

22 ity to respond rapidly and effectively to local mar-

23 keting and regulatory conditions (including health

24 care reform legislation that might be enacted by the

25 States); and

1           (2) granting the Department the authority and  
2           resources to facilitate the timely acquisition of nec-  
3           essary facilities and services at a local level.

4   **SEC. 903. HEALTH CARE REFORM BY THE STATES.**

5           (a) INTENT OF CONGRESS.—It is the intent of Con-  
6           gress that the Department of Veterans Affairs health care  
7           facilities shall participate as health care providers recog-  
8           nized under health care reform legislation enacted by the  
9           several States. To the extent practicable, the Secretary of  
10          Veterans Affairs shall provide health care services in a  
11          State enacting such reform legislation as if such facilities  
12          were providers under such legislation of that State.

13          (b) PROHIBITION.—Notwithstanding any other provi-  
14          sion of law, a State that enacts health care reform legisla-  
15          tion may not prohibit the participation of the Department  
16          as a health care provider under such legislation unless the  
17          chief executive officer of the State certifies to the Sec-  
18          retary that—

19                (1) the benefits to be provided by the Depart-  
20                ment do not meet the requirements for quality of  
21                benefits established by the reform legislation; or

22                (2) the location of Department facilities (includ-  
23                ing facilities providing services by contract or agree-  
24                ment with the Secretary) in the State is such that  
25                the proximity of eligible persons to such facilities



1 does not meet the requirements so established for  
2 such proximity.

3 **SEC. 904. AUTHORITY TO EXEMPT DEPARTMENT OF VETER-**  
4 **ANS AFFAIRS HEALTH CARE FACILITIES**  
5 **FROM CERTAIN PROVISIONS OF LAW.**

6 (a) IN GENERAL.—Chapter 73 of title 38, United  
7 States Code, is amended—

8 (1) by redesignating subchapter IV as sub-  
9 chapter V; and

10 (2) by inserting after subchapter III the follow-  
11 ing new subchapter IV:

12 “SUBCHAPTER IV—EXEMPTIONS

13 “§ 7341. **Designation of exempt facilities**

14 “In order to facilitate the provision of health care  
15 services by the Department in a manner that is responsive  
16 to local market and regulatory conditions, the Secretary  
17 may designate health care facilities of the Department  
18 which shall be exempt from provisions of law as specified  
19 in this subchapter.

20 “§ 7342. **Contracts and agreements**

21 “(a) If designated by the Secretary under section  
22 7341 of this title to be exempt from provisions of law as  
23 specified in this subchapter, a health care facility of the  
24 Department may enter into contracts and agreements for  
25 the provision of health care services and contracts and

1 agreements for other services (including procurement of  
2 equipment, maintenance and repair services, and other  
3 services related to the provision of health care services)  
4 as specified in this section.

5 “(b) Contracts and agreements (including leases)  
6 under subsection (a) shall not be subject to the following  
7 provisions of law:

8 “(1) Section 8110(c) of this title, relating to  
9 contracting of services at Department health care fa-  
10 cilities.

11 “(2) Section 8122(a)(1) of this title, relating to  
12 the lease of Department property.

13 “(3) Section 8125 of this title, relating to local  
14 contracts for the procurement of health care items.

15 “(4) Section 702 of title 5, relating to the right  
16 of review of agency wrongs by the courts of the  
17 United States.

18 “(5) Sections 1346(a)(2) and 1491 of title 28,  
19 relating to the jurisdiction of the district courts of  
20 the United States and the United States Court of  
21 Federal Claims, respectively, for the actions enumer-  
22 ated in such sections.

23 “(6) Subchapter V of chapter 35 of title 31, re-  
24 lating to the adjudication of protests of violations of  
25 procurement statutes and regulations.

1           “(7) Sections 3526 and 3702 of such title, re-  
2           lating to the settlement of accounts and claims, re-  
3           spectively, of the United States.

4           “(8) Subsection (b)(7), (e), (f), (g), and (h) of  
5           section 8 of the Small Business Act (15 U.S.C.  
6           637(b)(7), (e), (f), (g), and (h)), relating to require-  
7           ments with respect to small businesses for contracts  
8           for property and services.

9           “(9) The provisions of law assembled for pur-  
10          poses of codification of the United States Code as  
11          section 471 through 544 of title 40 that relate to the  
12          authority of the Administrator of General Services  
13          over the lease and disposal of Federal Government  
14          property.

15          “(10) The provisions of the Office of Federal  
16          Procurement Policy Act (41 U.S.C. 401 et seq.), re-  
17          lating to the procurement of property and services  
18          by the Federal Government.

19          “(11) Chapter 3 of the Federal Property and  
20          Administrative Services Act of 1949 (41 U.S.C. 251  
21          et seq.), relating to the procurement of property and  
22          services by the Federal Government.

23          “(12) Office of Management and Budget Cir-  
24          cular A-76.

1       “(c)(1) Notwithstanding any other provision of law,  
2 contracts and agreements for the provision of health care  
3 services under this section may include contracts and  
4 agreements with insurers, health care providers, or other  
5 individuals or entities that provide health care services.

6       “(2) Contracts and agreements under this subsection  
7 may be entered into without prior review by the Central  
8 Office of the Department.

9       “(d)(1) A contract or agreement under this section  
10 for services other than the services referred to in sub-  
11 section (c) (including a contract or agreement for procure-  
12 ment of equipment, maintenance and repair services, and  
13 other services related to the provision of health care serv-  
14 ices) shall not be subject to prior review by the Central  
15 Office of the Department if the amount of the contract  
16 or agreement is less than \$250,000.

17       “(2) The Central Office may conduct a prior review  
18 of a contract or agreement referred to in paragraph (1)  
19 if the amount of the contract or agreement is \$250,000  
20 or greater.

21       **“§ 7343. Department personnel**

22       “Notwithstanding any other provision of law, with re-  
23 spect to facilities designated by the Secretary under sec-  
24 tion 7341 of this title to be exempt from provisions of law  
25 as specified in this subchapter, the Secretary may—

1           “(1) appoint health care personnel to positions  
2           in that facility in accordance with such qualifications  
3           for such positions as the Secretary may establish;  
4           and

5           “(2) promote and advance personnel serving in  
6           such positions in accordance with such qualifications  
7           as the Secretary may establish.

8   **“§ 7344. Funding**

9           “(a) To the extent authorized by current law, the Sec-  
10          retary may continue to collect funds from third party pay-  
11          ers to defray the costs of providing health care services  
12          to veterans.

13          “(b) As a repository for funds referred to in sub-  
14          section (a), there is established in the Treasury a fund  
15          to be known as the Department of Veterans Affairs Health  
16          Care Reform Fund (hereafter referred to in this section  
17          as the ‘Fund’).

18          “(c)(1) Notwithstanding any other provision of law,  
19          amounts shall be deposited in the Fund as follows:

20                 “(A) Amounts collected as referred to in sub-  
21                 section (a).

22                 “(B) Amounts made available based on a deter-  
23                 mination under subsection (d).

24                 “(C) Amounts transferred to the Fund under  
25                 subsection (e).

1           “(D) Such other amounts as the Secretary de-  
2           termines to be necessary.

3           “(E) Such other amounts as may be appro-  
4           priated to the Fund.

5           “(2) The Secretary shall make available amounts  
6           under subparagraphs (B) and (D) of paragraph (1) from  
7           amounts appropriated to the Department of Veterans Af-  
8           fairs for the provision of health care services.

9           “(3) The Secretary shall establish and maintain a  
10          separate account under the Fund for each health care fa-  
11          cility designated under section 7341 of this title as exempt  
12          from the provisions of law as specified in this subchapter.  
13          Any deposits and expenditures with respect to a des-  
14          ignated facility shall be made to or from the account es-  
15          tablished and maintained with respect to that facility.

16          “(d)(1) For each year of the operation of a des-  
17          ignated facility, the Secretary shall deposit in the account  
18          of the Fund for the facility an amount (as determined by  
19          the Secretary) equal to the amount that would otherwise  
20          be made available to the facility for the payment of the  
21          cost of health care services by the facility in that year.  
22          The Secretary shall deposit such amount at the beginning  
23          of such year.

1       “(2) The costs referred to in paragraph (1) shall not  
2 include costs relating to the provision by the Secretary of  
3 the following services:

4           “(A) Services relating to post-traumatic stress  
5 disorder.

6           “(B) Services relating to spinal-cord injuries.

7           “(C) Services relating to substance abuse.

8           “(D) Services relating to the rehabilitation of  
9 blind veterans.

10       “(e) Funds deposited in the Medical-Care Cost Re-  
11 covery Fund established under section 1729(g) of this title  
12 during any fiscal year in an amount in excess of the Con-  
13 gressional Budget Office baseline (as of the date of the  
14 enactment of the Veterans Health Care Administrative  
15 Flexibility Act of 1994) for deposits in that fund for that  
16 fiscal year shall not be subject to paragraph (4) of section  
17 1710(f), 1712(f), or 1729(g) of this title, as the case may  
18 be, but shall be transferred to the Fund. Such transfer  
19 for any fiscal year shall be made at any time that the total  
20 of amounts so received less amounts estimated to cover  
21 the expenses, payments, and costs described in paragraph  
22 (3) of section 1729(g) of this title is in excess of the appli-  
23 cable Congressional Budget Office baseline.

24       “(f) Notwithstanding any other provision of law, the  
25 facility director for each facility designated under section

1 7341 of this title as exempt from the provisions of law  
2 as specified in this subchapter shall determine the costs  
3 for which amounts in the Fund may be expended in pro-  
4 viding health care services at that facility.

5 **“§ 7345. Expenditure authority**

6 “(a)(1) Except as provided in paragraph (2), if des-  
7 ignated by the Secretary under section 7341 of this title  
8 to be exempt from provisions of law as specified in this  
9 subchapter, a health care facility of the Department may  
10 expend funds under this section in order to cover the fol-  
11 lowing costs:

12 “(A) Costs of marketing and advertising health  
13 care services.

14 “(B) Costs of legal services provided to the fa-  
15 cility by the General Counsel of the Department re-  
16 lating to this subchapter.

17 “(C) Costs relating to acquisition (including ac-  
18 quisition of land), construction, repair, or renovation  
19 of facilities.

20 “(2) Costs under this section shall not include costs  
21 relating to a major medical facility project or a major  
22 medical facility lease as such terms are defined in sub-  
23 paragraphs (A) and (B) of section 8104(a)(3) of this title,  
24 respectively.”.



1 (b) CLERICAL AMENDMENT.—The table of sections  
 2 at the beginning of chapter 73 is amended by striking out  
 3 the item relating to the heading for subchapter IV and  
 4 inserting in lieu thereof the following:

“SUBCHAPTER IV—EXEMPTIONS

“7341. Designation of exempt facilities.

“7342. Contracts and agreements.

“7343. Department personnel.

“7344. Funding.

“7345. Expenditure authority.

“SUBCHAPTER V—RESEARCH CORPORATIONS”.

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S 2374 IS—3

S 2374 IS—4

S 2374 IS—5

S 2374 IS—6

S 2374 IS—7

S 2374 IS—8

S 2374 IS—9

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